








Occupational stress, work engagement and coping strategies in Community Health Workers*

Estresse ocupacional, *work engagement* e estratégias de enfrentamento em Agentes Comunitários de Saúde

How to cite this article:

Faria FRC, Lourenção LG, Silva AG, Sodr  PC, Castro JR, Borges MA, et al. Occupational stress, work engagement and coping strategies in Community Health Workers. Rev Rene. 2021;22:e70815. DOI: <https://doi.org/10.15253/2175-6783.20212270815>

 Francieli Regini Carvalho de Faria¹
 Luciano Garcia Lourenção²
 Albertina Gomes da Silva¹
 Paula Canova Sodr ³
 Jussara Rossi Castro¹
 M rcio Andrade Borges²
 Cl udia Eli Gazetta¹

*Extracted from the dissertation "Estresse ocupacional, engajamento e estrat gias de enfrentamento em Agentes Comunit rios de Sa de", Faculdade de Medicina de S o Jos  do Rio Preto, 2020.

¹Faculdade de Medicina de S o Jos  do Rio Preto. S o Jos  do Rio Preto, S o Paulo, Brazil.

²Universidade Federal do Rio Grande. Rio Grande, RS, Brazil.

³Secretaria Municipal de Sa de. S o Jos  do Rio Preto, S o Paulo, Brazil.

Corresponding author:

Luciano Garcia Lourenção
Rua General Os rio, s/n. Campus da Sa de, Sala 10.
Centro. CEP: 96200-400. Rio Grande, RS, Brazil.
E-mail: lucianolourencao.enf@gmail.com

ABSTRACT

Objectives: to evaluate the levels of occupational stress, work engagement, and coping strategies among community health workers. **Methods:** cross-sectional study with 133 Community Health Workers. We used a questionnaire with socioeconomic and professional variables, the Work Stress Scale, the Utrecht Work Engagement Scale, and the Coping Modes Scale. **Results:** The mean occupational stress score was 2.7. Work engagement levels were high for dedication (4.0), vigor (4.3), and overall score (4.0). Problem-focused coping modes (3.9; ± 0.6) and based on religious practices and fantasy thinking (3.4; ± 0.7) stood out. **Conclusion:** there is a high percentage of professionals with significant occupational stress. The levels of work engagement were medium for absorption and high for dedication, vigor, and overall score. The coping strategies are focused on problem solving, religious practices and fanciful thoughts of positive character.

Descriptors: Primary Health Care; Community Health Workers; Work Engagement; Occupational Stress; Adaptation, Psychological.

RESUMO

Objetivos: avaliar os n veis de estresse ocupacional, *work engagement* e estrat gias de enfrentamento em agentes comunit rios de sa de. **M todos:** estudo transversal com 133 Agentes Comunit rios de Sa de. Foram utilizados um question rio com vari veis socioecon micas e profissionais, a Escala de Estresse no Trabalho, a *Utrecht Work Engagement Scale* e a Escala Modos de Enfrentamento de Problemas. **Resultados:** o escore m dio do estresse ocupacional foi 2,7. Os n veis de *work engagement* foram altos para dedica o (4,0), vigor (4,3) e escore geral (4,0). Destacaram-se os modos de enfrentamento Focalizados no Problema (3,9; $\pm 0,6$) e Baseados na busca de pr ticas religiosas e pensamento fantasioso (3,4; $\pm 0,7$). **Conclus o:** h  um percentual elevado de profissionais com estresse ocupacional importante. Os n veis de *work engagement* foram m dios para a absor o e altos para dedica o, vigor e escore geral. As estrat gias de enfrentamento est o voltadas para a focaliza o na resolu o do problema, pr ticas religiosas e pensamentos fantasiosos de car ter positivo.

Descritores: Aten o Prim ria   Sa de; Agentes Comunit rios de Sa de; Engajamento no Trabalho; Estresse Ocupacional; Adapta o Psicol gica.

EDITOR IN CHIEF: Ana Fatima Carvalho Fernandes
ASSOCIATE EDITOR: Renan Alves Silva

Introduction

Community Health Workers are part of the Family Health Teams as health professionals because they have the technical knowledge that allows them to transmit information on health promotion and disease prevention, and as community residents, they bring with them the culture, customs, and popular knowledge of the local society, so that this proximity creates the desired links with the health service⁽¹⁾.

In the current panorama of the health of workers in the Brazilian Unified Health System, there is a growing precariousness of work, with temporary employment contracts and low wages, which generate overload and emotional stress, and can compromise the quality of life and health of community workers. Moreover, this situation impacts the relationship between these professionals and the community, due to the great proximity they have with users⁽²⁻³⁾.

From a set of relationships and interactions, these professionals play an important role in facilitating community access to services and health care actions developed by Primary Care. However, they are often pressured by the community regarding the flows and the resolution of demands, such as scheduling appointments and exams, and may feel guilty for the weaknesses of the system⁽⁴⁻⁵⁾.

In this context, there is an overload of community health workers, resulting from the set of work demands, associated with the intense emotional involvement with the user, the low recognition and little appreciation of their efforts by the community, managers, and public authorities, which can cause demotivation and illness in these professionals⁽⁶⁻⁸⁾.

Although occupational stress is part of work life and is considered useful in small levels, continuous stress, or an inadequate response to it is harmful and can produce negative impact on work and worker health, affecting the community that suffers with absenteeism, emotional problems, and irregular performance of professionals, besides their impatience with the population⁽²⁾.

The development of strategies to minimize stress is important to avoid damage to the worker's health and improve their job satisfaction, producing motivation. Besides the individual care with the workers, it is necessary to think and act collectively with all the actors involved in the labor process. However, the intense work routine makes community health workers seek help only when they feel completely worn out or exhausted⁽⁶⁻⁷⁾.

Coping strategies consist of the different ways professionals deal with daily stress situations and involve behavioral and cognitive efforts created to control the demands and circumstances that overwhelm individuals or exceed their personal resources⁽⁹⁾. They are necessary to prevent health damage and produce motivation, improving job satisfaction. One of the most common strategies among community health workers is to find affective and social support to face the problems and difficulties in dealing with the limits of personal life⁽⁶⁻⁷⁾.

Despite the stress present in the work practice of these professionals, there is pleasure and satisfaction in their occupational activities when there is appreciation and recognition and situations such as manifestations of affection and gratitude of users for the work done, which shows a relationship where there is integration of professionals with the team and managers⁽¹⁰⁾. And, despite all the difficulties, the engagement of community health workers in the work is noted⁽¹⁾.

Which shows that when professionals are engaged, greater investments in their physical, psycho-emotional, and cognitive development are made, leading to an increase in their work performance, because they present higher levels of extrafunction behavior, performing actions that go beyond their responsibilities. Therefore, they become more focused on their tasks and responsibilities and work more intensely⁽¹¹⁾.

Considering that engaged professionals are essential for the efficiency and success of the organization, it becomes relevant to study *work engagement*. On the one hand, professional wear and loss of energy

are linked to high work demands, poor job structure, and low levels of resources, which can lead to physical and mental exhaustion and cause health problems; on the other hand, even in the face of adversity and scarcity of resources, work can become motivational and lead professionals to high engagement and high performance at work⁽¹²⁾.

Therefore, this study aimed to evaluate the levels of occupational stress, *work engagement*, and coping strategies among community health workers.

Methods

Cross-sectional study, conducted in the period from February to June 2017, with community health workers of the Family Health teams in the municipality of São José do Rio Preto, São Paulo, Brazil.

At the time of data collection, the municipality was divided into five Health Districts with 27 Primary Care units, 10 Basic Health Units and 17 Family Health Units with 40 Family Health Strategy teams covering 24% of the population. The study population consisted of 260 Community Health Workers from the municipality's Family Health teams. The study sample was defined by convenience and composed of 133 professionals who answered the instruments.

Data were collected during team meetings, after scheduling with the managers of the health units. The researchers explained the objectives of the study and delivered the questionnaires and the Informed Consent Forms in separate sealed envelopes, which could be answered at the workplace or in another environment and were returned after a week in the respective separate sealed envelopes to preserve the anonymity of the study participants.

Four self-applied instruments were used, one with sociodemographic and professional variables; the Work Stress Scale (WSS)⁽¹³⁾; the Brazilian version of the Utrecht Work Engagement Scale (UWES)⁽¹⁴⁾; and the Problem Coping Modes Scale⁽¹⁵⁾. The WSS consists of 23 negative statements and with answers

on a five-point Likert scale, ranging from: 1 - strongly disagree, 2 - disagree, 3 - partially agree, 4 - agree and 5 - strongly agree and the higher the score, the higher the stress. The internal consistency (Cronbach's alpha) of the scale was equivalent to 0.91⁽¹³⁾. The UWES consists of 17 self-assessment items with three dimensions (Vigor, Dedication and Absorption) and a general score^(11,14). The internal consistency of the scale in the Brazilian population was high (Cronbach's alpha = 0.95), indicating good validity for our cultural context⁽¹⁴⁾.

The Problem Coping Modes Scale is composed of 45 items that address four factors: coping strategies focused on the problem (Factor 1); coping strategies focused on emotion (Factor 2); search for religious practices/fantastical thinking (Factor 3) and search for social support (Factor 4). The Problem Coping Modes Scale items are answered on a *Likert* type scale with five possible responses: 1 - I never do this; 2 - I do this a little; 3 - I do this sometimes; 4 - I do this a lot; 5 - I do this always. The Problem Coping Modes Scale adapted for the Brazilian population showed the following consistency values: Factor 1: $\alpha=0.84$; Factor 2: $\alpha=0.81$; Factor 3: $\alpha=0.74$, and Factor 4: $\alpha=0.70$ ⁽¹⁵⁾.

For the professionals who were not present at the meeting, the questionnaires and the Informed Consent Form were left by the researchers with the managers of the units, who delivered and collected them in separate, sealed envelopes and handed them to the researchers later, no later than 30 days.

Data were analyzed using the Statistical Package for the Social Sciences, version 20.0. The population was characterized by sociodemographic and professional variables. For the evaluation of occupational stress, the overall mean score obtained by the community health workers was calculated, as well as a score for each item of the scale, to identify the most stressful factors. Mean values equal to or greater than 2.5 indicate important levels of stress⁽¹³⁾.

To calculate the scores of the dimensions of *work engagement*, the proposed statistical model was

used, indicating mean and standard deviation for each dimension of the UWES scale. Based on the calculation of the scores, we proceeded to interpret the values obtained, according to the decoding of the UWES Preliminary Manual, being: Very Low = 0 to 0.99; Low = 1 to 1.99; Medium = 2 to 3.99; High = 4 to 4.99; Very High = 5 to 6⁽¹⁴⁾. For the analysis of the problem coping modes, a mean score was calculated for each factor of the WSS, considering the items that make up each factor and each item of the scale, identifying those with higher means⁽¹⁵⁾.

The study was approved by the Research Ethics Committee of the Faculdade de Medicina de São José do Rio Preto, under Certificate of Ethical Appraisal Submission No. 59604116.0.0000.5415 and Opinion No. 1,776,737/2016.

Results

Study composed of 133 community health workers, 105 (78.9%) were female, 71 (53.4%) between 31 and 50 years of age, 78 (58.6%) were married, 102 (76.7%) had high school education, 124 (93.2%) were permanent employees, 105 (78.9%) had family income of two to five minimum wages, 85 (63.9%) did not practice physical activity, 98 (73.7%) had six to eight hours of sleep a day, 82 (61.7%) were satisfied with their profession, 98 (73.7%) had been working for up to two years, and 76 (57.1%) had already thought about quitting the profession.

The levels of community health workers' work engagement ranged from 3.8 to 4.3 and were classified as medium for the absorption dimension and high for the dedication, vigor, and overall score dimensions, as shown in Table 2. Cronbach's Alpha Coefficient values ranged from 0.827 to 0.936 and point to the reliability of the results (Table 1).

Table 1 – Assessment of the levels of the Utrecht Work Engagement Scale of Community Health Workers. São José do Rio Preto, SP, Brazil, 2017. (n=133)

Dimensions	Cronbach's Alpha	Mini-mum	Maxi-mum	Media ±sd	CI (95%)	Interpretation
Dedication	0.836	0	6.0	4.0±1.4	3.7 – 4.2	High
Absorption	0.827	0.5	6.0	3.8±1.42	3.6 – 4.0	Medium
Vigor	0.840	0.8	6.0	4.3±1.5	4.1 – 4.5	High
General Score	0.936	0.5	6.0	4.0±1.3	3.8 – 4.2	High

Sd: Standard deviation, CI: 95% Confidence Interval

The internal consistency of the WSS for this study was $\alpha=0.91$. In the analysis of the overall occupational stress score, 74 community health workers (56.4%) presented scores compatible with major occupational stress (>2.5). The mean stress level of the sample was 2.7 (SD = ± 0.7 ; 95% CI = 2.6 - 2.8). As shown in Table 2, the stressful factors, according to the perception of community health workers, were: Q13: deficiency in professional training (3.8±1.2); Q16: lack of perspectives of career growth (3.5±1.42); Q5: deficiency in information disclosure about organizational decisions (3.3±1.2); Q12: presence of discrimination/favoritism in the work environment (3.1±1.4); Q1: form of task distribution (3.0±1.3); Q3: lack of autonomy in work performance (3.0±1.2); Q2: type of control (2.9±1.1); Q6: lack of information about tasks at work (2.9±1.2); Q22: insufficient time to perform work (2.9±1.2). Q15: low appreciation by superiors (2.7±1.2); Q17: tasks below skill level (2.6±1.3); Q19: lack of understanding the responsibilities (2.5±1.1); Q18: competition in the work environment (2.5±1.2); Q9 and: performing tasks that are beyond ability (2.5±1.3).

Table 2 – Rating of the items of the Job Stress Scale, according to the perception of the Community Health Workers. São José do Rio Preto, SP, Brazil, 2017. (n=133)

Items	Mean (\pm standard deviation)
Q1 - The way tasks are distributed in my area has made me nervous	3.0 (\pm 1.3)
Q2 - The type of control that exists in my job makes me angry	2.9 (\pm 1.1)
Q3 - The lack of autonomy in doing my job has been stressful	3.0 (\pm 1.2)
Q4 - I have been bothered by my superior's lack of trust in my work	2.1 (\pm 1.2)
Q5 - I am annoyed by poor disclosure of information about organizational decisions	3.3 (\pm 1.2)
Q6 - I am annoyed by the lack of information about my job tasks	2.9 (\pm 1.2)
Q7 - Lack of communication between myself and my co-workers makes me angry	2.4 (\pm 1.1)
Q8 - I am annoyed that my superior treats me badly in front of coworkers	2.4 (\pm 1.5)
Q9 - I am annoyed by having to perform tasks that are beyond my ability	2.5 (\pm 1.3)
Q10 - I feel bad about having to work for many hours at a time	2.2 (\pm 1.1)
Q11 - I am uncomfortable with the communication between myself and my superior	2.2 (\pm 1.2)
Q12 - I am annoyed by discrimination/favoritism in my work environment	3.1 (\pm 1.4)
Q13 - I have been bothered by deficiencies in job training	3.8 (\pm 1.2)
Q14 - I am annoyed by feeling isolated in the organization	2.1 (\pm 1.1)
Q15 - I get irritated by being undervalued by my superiors	2.7 (\pm 1.2)
Q16 - The few perspectives of career growth have left me distressed	3.5 (\pm 1.4)
Q17 - I have felt uncomfortable working on tasks below my skill level	2.6 (\pm 1.3)
Q18 - Competition in my work environment has put me in a bad mood	2.5 (\pm 1.2)
Q19 - Lack of understanding of what my responsibilities are in this job has caused irritation	2.5 (\pm 1.1)
Q20 - I have been nervous about my superior giving me contradictory orders	2.1 (\pm 1.0)
Q21 - I feel irritated that my superior covers up my job well done in front of other people	2.1 (\pm 1.1)
Q22 - Insufficient time to accomplish my workload makes me nervous	2.9 (\pm 1.2)
Q23 - I am annoyed that my superior avoids assigning me important responsibilities	2.2 (\pm 1.0)

Regarding the coping mode used by community health workers, the strategies of Problem-Focused Coping (3.9 ± 0.6) and Coping based on the search for religious practices and fanciful thinking (3.4 ± 0.7) stood out (Table 3).

Table 3 – Descriptive analysis of the Scale of Problem Coping Modes of the Community Health Workers. São José do Rio Preto, SP, Brazil, 2017. (n=133)

Strategy	Cronbach's Alpha	Average	Standard Deviation
Problem-focused	0.86	3.9	0.6
Emotion-focused	0.81	2.5	0.6
Search for religious practices and wishful thinking	0.71	3.4	0.7
Search for social support	0.69	3.2	0.9

The Problem Coping Modes Scale items that showed higher mean scores were: I pray/pray (4.7 ± 1.0); I try to be a stronger and more optimistic person (4.4 ± 0.8); I focus on the good things in my life (4.3 ± 0.8); I push and fight for what I want (4.2 ± 0.9); I try to keep my feelings from getting in the way of other things in my life (4.1 ± 0.9); I accept someone's sympathy and understanding (4.1 ± 0.9); I know what should be done and I am increasing my efforts to be successful (4.1 ± 0.9); I am changing and becoming a more experienced person (4.1 ± 0.9); I dream or imagine a better time than the one I am in (4.1 ± 1.1).

Discussion

The main limitations of this study are its cross-sectional design, which makes it impossible to esta-

blish cause and effect relationships; and the inclusion of professionals from a single municipality, which does not allow the generalization of the results.

On the other hand, the results show important aspects of the relationship between community health workers and their work, especially because these workers have their main assignment linked to the practice of health care. In addition, they show the importance and the need for community health workers to work under low levels of occupational stress, with good levels of work engagement and coping strategies that allow them to overcome adversities, contributing to expand the coverage of the Family Health Strategy and increase the effectiveness of access to basic health services by the population.

It is observed that during their work in the territory of the Family Health Unit, community health workers are often pressured and penalized by users about the network flows, which generates an important emotional pressure on these professionals⁽⁵⁾. The impact of this pressure is evidenced in this study by the high levels of stress related to lack of training, poor dissemination of information on organizational decisions, lack of autonomy and performance of tasks that are beyond the professional capacity of community health workers.

These results are reinforced by the literature, which points out the suffering of many professionals in Primary Health Care with occupational stress, especially community health workers for being among the professional categories with the highest level of stress and dissatisfaction with their work performance⁽¹⁶⁾.

The high percentage of community health workers with an important level of occupational stress can be explained by the time these professionals have been working in primary health care services, since the literature describes that stress is greater after the first year of work^(6-7,16). In this context, occupational stress can be a risk factor for abandonment of the function, generating high turnover of these workers in the Family Health Care teams and hindering the development of a bond with families and the community,

which can compromise the resolutivity capacity of the Family Health Strategy in the territories^(6-7,16).

In addition, these results highlight the importance of community health workers receiving training to deal with the psychic burdens present in their work activity, such as living with people in poor socioeconomic and health situations, hunger and unemployment, chemical dependency, situations of violence abandonment and neglect, lack of understanding and resistance of users, high emotional load resulting from the involvement with the community, severity of health problems and family relationships, intense work rhythm and low recognition, in addition to the overvaluation of violence and bureaucracy as factors of insecurity⁽¹⁷⁾.

Another factor pointed out as fundamental for the reduction of occupational stress is the guarantee of more stable working conditions for the professionals of the Family Health Strategy, especially hiring, since the singularity of the work in this care model and the requirement of full time reinforce the need for greater stability for workers, such as hiring through public competitions⁽⁵⁾.

Professional satisfaction, pointed out in this study by more than 60% of community health workers, is widely discussed by specialists in organizational behavior, especially in relation to the impacts caused on the workers' health⁽⁶⁻⁸⁾. When the community listens and receives community health workers with attention, these professionals feel extremely valued and satisfied, because they can bring about positive changes that reflect in the quality of care provided⁽¹⁶⁻¹⁷⁾.

In turn, job satisfaction is associated with occupational stress to the extent that professionals with higher levels of satisfaction have better levels of stress and can better cope with stressors⁽¹⁶⁾. The results of this study are in line with such statement, since, despite being satisfied with their profession, it was observed that most community health workers have high levels of occupational stress, the professionals studied show high levels of work engagement, mainly related to: high energy and mental toughness; high desire to

invest in the work, with effort and persistence; and the strong involvement with the work, with feelings of enthusiasm, inspiration and pride, corroborating studies with professionals in Primary Health Care⁽¹⁶⁻¹⁷⁾.

And, although some researchers consider that *work engagement* levels are independent of the degree of organizational commitment, of the level of satisfaction with the job and of organizational citizenship behavior, there are others who defend the existence of a positive relationship between work engagement and job satisfaction and consider that job satisfaction is a variable that precedes work engagement. Thus, the high level of *work engagement* presented by community health workers may explain their feeling of satisfaction, regardless of the presence of occupational stressors^(10,12).

In addition, engaged workers tend to experience more positive emotions and have better physical and mental health status due to greater participation in social and leisure activities that promote relaxation and psychological detachment from work, such as physical exercise⁽¹⁰⁾.

Nevertheless, the ways of coping presented by community health workers can also corroborate to the strengthening of satisfaction levels and engagement at work, since these professionals use their own interventional measures to minimize the psychological stress arising from the work process, such as the search for religious practices; of support in affective networks, such as family, friends, and people who bring security or sustenance in social support, such as co-workers who allow the sharing of emotions⁽¹⁸⁾.

In this sense, it is believed that nurses who are responsible for coordinating and managing community health workers, as well as municipal managers, can create institutional spaces in the Units and health teams to listen and reflect on the demands of community health workers, helping them to manage their difficulties in developing their functions as mediators between the health system and the attached users, in order to meet the demands of users of the Unified Health System, without the mental illness of these community health workers.

Conclusion

The main stressors, in the perception of the professionals, were training deficits; and in the disclosure of information about organizational decisions; lack of career growth perspectives and discrimination/favoritism in the work environment.

The problem coping strategies are focused on problem solving, religious practices, and fanciful thoughts of positive character. And, regarding the levels of *work engagement* of community health workers, these are favorable, especially regarding dedication (involvement with the work, feelings of enthusiasm, inspiration, and pride) and vigor (mental energy and stamina desire to invest in the work, effort, and persistence).

Collaborations

Faria FRC contributed to the writing of the article. Lourenção LG and Gazetta CE contributed to the design, analysis, and interpretation of the data. Silva AG, Sodré PC, Castro JR, and Borges MA contributed to the relevant critical review of the intellectual content. All authors approved the final version to be published.

References

1. Riquinho DL, Pellini TV, Ramos DT, Silveira MR, Santos VCF. O cotidiano de trabalho do agente comunitário de saúde: entre a dificuldade e a potência. *Trab Educ Saúde*. 2018; 16(1):163-82. doi: <https://doi.org/10.1590/1981-7746-sol00086>
2. Almeida MCS, Baptista PCP, Silva A. Workloads and strain process in Community Health Agents. *Rev Esc Enferm USP*. 2016; 50(1):93-100. doi: <https://dx.doi.org/10.1590/S0080-623420160000100013>
3. Pinto AGA, Palácio MAV, Lôbo AC, Jorge MSB. Vínculos subjetivos do agente comunitário de saúde no território da Estratégia Saúde da Família. *Trab Educ Saúde*. 2017; 15(3):789-802. doi: <https://doi.org/10.1590/1981-7746-sol00071>

4. Assegaai T, Schneider H. The supervisory relationships of community health workers in primary health care: social network analysis of ward-based outreach teams in Ngaka Modiri Molema District, South Africa. *BMJ Glob Health*. 2019; 4:e001839. doi: <https://dx.doi.org/10.1136/bmjgh-2019-001839>
5. Balk RS, Holstein JM, Lara S, Graup S. M todo Pilates: uma estrat gia reabilitadora do estresse em Agentes Comunit rios de Sa de. *Sa de (Sta. Maria)*. 2018; 44(2):1-12. doi: <https://dx.doi.org/10.5902/2236583426672>
6. Miranda BAB, Pegoraro RF. Quality of life and psychological distress in community health workers. *REFACS*. 2021; 9(Suppl. 1):202-15. doi: <https://doi.org/10.18554/refacs.v9i0.4451>
7. Santos AC, Hoppe AS, Krug SBF. Agente Comunit rio de Sa de: implica es dos custos humanos laborais na sa de do trabalhador. *Physis*. 2018; 28(4):e280403. doi: <https://dx.doi.org/10.1590/s0103-73312018280403>
8. Alonso CMC, Beguin PD, Duarte FJC. Work of community health agents in the Family Health Strategy: meta-synthesis. *Rev Sa de P blica*. 2018; 52:14. doi: <https://dx.doi.org/10.11606/s1518-8787.2018052000395>
9. Lazarus RS, Folkman S. The concept of coping. In: Monart A, Lazarus RS, organizadores. *Stress and Coping: an anthology*. New York: Columbia University Press; 1991.
10. Soratto J, Pires DEP, Scherer MDA, Witt RR, Ceretta LB, Farias JM. Family health strategy professional satisfaction in Brazil: a qualitative study. *Texto Contexto Enferm*. 2020; 29:e20180104. doi: <http://doi.org/10.1590/1980-265x-tce-2018-0104>
11. Rotta DS, Louren o LG, Gonsalez EG, Teixeira PR, Gazetta CE, Pinto MH. Engagement of multi-professional residents in health. *Rev Esc Enferm USP*. 2019; 53:e03437. doi: <http://dx.doi.org/10.1590/s1980-220x2018003103437>
12. Bakker AB, Demerouti E. Job demands-resources theory: taking stock and looking forward. *J Occup Health Psychol*. 2017; 22(3):273-85. doi: <https://doi.org/10.1037/ocp0000056>
13. Paschoal TE, Tamayo A. Validation of the work stress scale. *Estud Psicol*. 2004; 9(1):45-52. doi: [10.1590/S1413-294X2004000100006](https://doi.org/10.1590/S1413-294X2004000100006)
14. Vazquez ACS, Magnan ES, Pacico JC, Hutz CS, Schaufeli WB. Adaptation and Validation of the Brazilian Version of the Utrecht Work Engagement Scale. *Psico-USF*. 2015; 20(2):207-17. doi: <http://dx.doi.org/10.1590/1413-82712015200202>
15. Seidl EMF, Tr ccoli BT, Zannon CMLC. An lise fatorial de uma medida de estrat gias de enfrentamento. *Psic Teor Pesq*. 2001; 17(3):225-34. doi: <https://dx.doi.org/10.1590/S0102-37722001000300004>
16. Cordioli DFC, Cordioli Junior JR, Gazetta CE, Silva AG, Louren o LG. Occupational stress and work engagement in primary health care workers. *Rev Bras Enferm*. 2019; 72(6):1580-7. doi: <http://dx.doi.org/10.1590/0034-7167-2018-0681>
17. Silva AG, Cabrera EMS, Gazetta CE, Sodr  PC, Castro JR, Cordioli Junior JR, et al. Engagement in primary health care nurses: a cross-sectional study in a Brazilian city. *Public Health Nurs*. 2020; 37(2):169-77. doi: <https://doi.org/10.1111/phn.12694>
18. Simas PRP, Pinto ICMP. Health work: portrait of community workers in the Northeast region of Brazil. *Ci nc Sa de Coletiva*. 2017; 22(6):1865-76. doi: <https://doi.org/10.1590/1413-81232017226.01532017>



This is an Open Access article distributed under the terms of the Creative Commons