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The quality of life of family health professionals: a systematic review and meta-synthesis

Qualidade de vida de profissionais da Saúde da Família: uma revisão sistemática e metassíntese

Calidad de vida de profesionales de Salud de la Familia: una revisión sistemática y metasíntesis

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ABSTRACT

Objectives: to perform a systematic review and meta-synthesis of qualitative studies about the work-related quality of life of Family Health Strategy professionals. **Methods:** this systematic review was developed to answer the following PVO question: "Which factors (variables) are associated with the work-related quality of life (outcome) of Family Health Strategy professionals (population)?" The PubMed, Scopus, Embase, SciELO, Web of Science, LILACS, Science Direct, OpenThesis, OpenGrey, and OATD databases were selected. The meta-synthesis analyzed the main codes and secondary codes of all included studies. **Results:** the database search resulted in 1,744 reports; six were considered eligible for the meta-synthesis. Four factors were considered for the quality of work life: working conditions; work processes; interpersonal relationships; and personal aspects. **Conclusions:** although this study confirms the adequacy of aspects commonly related to the quality of work life, other factors are important in the case of FHS professionals, especially work context.

Descriptors: Family Health; Systematic Review; Quality of Life; Occupational Health; Primary Health Care.

RESUMO

Objetivos: desenvolver uma revisão sistemática e metanálise de estudos qualitativos sobre a qualidade de vida relacionada ao trabalho de profissionais da Saúde da Família. **Métodos:** a revisão sistemática foi desenvolvida para responder à seguinte questão pautada no método PVO: "Quais fatores (variáveis) estão associados com a qualidade de vida relacionada ao trabalho (resultado) de profissionais da Estratégia Saúde da Família (população)?" As bases de dados *PubMed*, Scopus, Embase, SciELO, *Web of Science*, LILACS, *Science Direct*, *OpenThesis*, *OpenGrey* e OATD foram selecionadas. A metassíntese analisou as categorias principais e subcategorias de todos os estudos incluídos. **Resultados:** a busca na base de dados resultou em 1.744 registros, e seis deles foram considerados elegíveis para a metassíntese. Quatro fatores foram considerados para a qualidade de vida relacionada ao trabalho: condições de trabalho, processo de trabalho, relações interpessoais e aspectos pessoais. **Conclus*ões*:** embora este estudo confirme a adequação de aspectos comumente relacionados à qualidade de vida no trabalho, outros fatores são importantes no caso dos profissionais da Saúde da Família, especialmente o contexto de trabalho.

Descritores: Saúde da Família; Qualidade de Vida; Revisão Sistemática; Saúde do Trabalhador; Atenção Primária em Saúde.

RESUMEN

Objetivos: desarrollar una revisión sistemática y metaanálisis de estudios cualitativos sobre la calidad de vida relacionada al trabajo de profesionales de Salud de la Familia. **Métodos:** la revisión sistemática se desarrolló para responder la siguiente pregunta pautada en metodología PVO: "¿Cuáles factores (variables) están asociados con la calidad de vida relacionada al trabajo (resultado) de profesionales de Estrategia Salud de la Familia (población)?". Fueron seleccionadas las bases *PubMed*, Scopus, Embase, SciELO, *Web of Science*, LILACS, *Science Direct*, *OpenThesis*, *OpenGrey* y OATD. La metasíntesis analizó las categorías principales y subcategorías de todos los estudios incluidos. **Resultados:** la búsqueda en bases halló 1.744 registros, seis de ellos fueron considerados elegibles para la calidad de vida relacionada al trabajo: condiciones laborales, proceso de trabajo, relaciones interpersonales y aspectos personales. **Conclusiones:** Aunque este estudio confirme que algunos aspectos habitualmente relacionados con la calidad de vida son adecuados, hay otros factores importantes para los profesionales de Salud de la Familia, particularmente el ámbito laboral.

Descriptores: Salud de la Familia; Revisión Sistemática; Calidad de Vida; Salud Laboral; Atención Primaria de Salud.

INTRODUCTION

The Family Health Strategy (FHS) is the main Brazilian primary healthcare service and is responsible for interventions in the social determinants of health. Family health is an organizational strategy of the Brazilian public health system that promotes integrated, equitable, and continuous care[1]. Expansion of access to primary care in Brazil may be identified through the great increase in the number of FHS teams implemented over the last 20 years. According to the data from the Department of Primary Care, that figure grew from 2,054 in July 1998 to 41,619 in October 2017[2].

Multi-professional teams provide health care in the FHS, and the standard structure includes physicians, nurses, nursing assistants, and community health workers. Dentists and auxiliary dental professionals may complement these teams. To extend the scope of their activities, these professionals may work together with Family Health Support Centers (FHSCs), which consists of professionals from different health fields[3]. Family Health Service professionals are responsible for patients living in their assigned territories, considering the social aspects of individuals and their relationships with their families and communities[1,3]. To fully exercise their functions, these professionals are required to preserve their quality of life, understanding that interfering factors may highly compromise the quality of care provided[4].

Quality of life is a multifaceted concept that considers individual perceptions of life status, adequacy of social contexts, culture and value systems, and relationships among goals, expectations, standards, and concerns[5]. It may be observed that quality of life is a generic concept applied to different contexts of life, in which work is a central dimension that contributes to creating personal identity[2]. Quality of Work Life (QWL) is an extension of the term "quality of life," and it designates multidimensional factors that refer to general satisfaction with life at work, the balance between personal and professional lives, a sense of belonging to the working group, and a sense of being valued and respected[6]. Scientific evidence has shown that the quality of life of health professionals has been well studied[7], but FHS professionals do not often discuss this topic.

OBJECTIVES

To perform a systematic review and meta-synthesis of qualitative studies on the work-related quality of life of FHS professionals.

METHODS

Protocol and registration

This systematic review was performed according to the list of Preferred Reporting Items for Systematic Review and Meta-Analysis Protocol (PRISMA-P) recommendations[8] and the Cochrane guidelines[9]. The systematic review protocol was registered in the PROSPERO database under no. CRD42019135759.

Study design and eligibility criteria

This study was a systematic review that aimed to answer the following guiding question based on the PVO strategy: Which factors (variables) are associated with the work-related quality of life (outcome) of Family Health Strategy professionals (population)?"

The inclusion criteria were qualitative studies about Work-Related Quality of Life (WRQoL) of Family Health Strategy (FHS) professionals, without restrictions as to year, publication status (ahead of print), or language. The exclusion criteria were: 1) Studies outside the objective; 2) Quantitative studies about quality of life in the FHS; 3) Review articles, letters to the editor/editorials, personal opinions, books/book chapters, textbooks, reports, and conference abstracts; 4) Studies with a high risk of bias.

Information sources and search strategy

The PubMed (including MedLine), Scopus, Embase, SciELO, Web of Science, Latin-American and Caribbean Health Sciences Literature (LILACS), and Science Direct databases were used as primary study sources. OpenThesis, OpenGrey, and OATD were used to partially capture the "grey literature." Additionally, a manual search was performed in the references of the studies eligible from the electronic search. All steps were performed to minimize selection and publication biases.

The MeSH (Medical Subject Headings), DeCS (Health Sciences Descriptors), and Emtree (Embase Subject Headings) resources were used to select appropriate search descriptors. The Boolean operators "AND" and "OR" were used to enhance the research strategy through several combinations (Chart 1). The search was performed in January 2019. The results obtained were exported to EndNote Web™ software (Thomson Reuters, Toronto, Canada), in which duplicates were removed. The remaining results were exported to Microsoft Word™ 2010 (Microsoft™ Ltd, Washington, USA), in which the remaining duplicates were removed manually.

Chart 1 - Strategies for database search.

Database	Search strategy (January 2019)	Results
PubMed http://www.ncbi.nlm.nih.gov/pubmed	("Quality of Life"[All Fields] OR "Health Related Quality Of Life"[All Fields] OR "Health-Related Quality Of Life"[All Fields] OR "Life Quality"[All Fields] OR "HRQOL"[All Fields]) AND ("Family Health"[All Fields] OR "Family Health Strategy"[All Fields] OR "Primary Health Care"[All Fields]) AND ("Health Occupation"[All Fields] OR "Health Worker"[All Fields] OR "Health Profession"[All Fields] OR "Health Personnel"[All Fields] OR "Occupational Health"[All Fields])	204
Scopus http://www.scopus.com/	("Quality of Life" OR "Life Quality") AND ("Family Health" OR "Family Health Strategy" OR "Primary Health Care") AND ("Health Occupation" OR "Health Worker" OR "Health Profession" OR "Health Personnel" OR "Occupational Health")	267
	("Quality of Life" OR "Health Related Quality Of Life" OR "Health-Related Quality Of Life" OR "Life Quality" OR "HRQOL") AND ("Family Health" OR "Family Health Strategy") AND ("Health Worker" OR "Health Profession" OR "Health Personnel")	62
LILACS http://lilacs.bvsalud.org/	("Quality of Life") AND ("Family Health") AND ("Health Personnel")	39
	("Qualidade de Vida") AND ("Saúde da Família") AND ("Saúde do Trabalhador")	30
	("Quality of Life") AND ("Family Health") AND ("Health Workers")	52

To be continued

Chart 1 (concluded)

Database	Search strategy (January 2019)	Results
SciELO http://www.scielo.org/	("Quality of Life") AND ("Family Health") AND ("Health Personnel")	5
	("Quality of Life") AND ("Family Health") AND ("Occupational Health")	5
	("quality of life") AND ("Family Health") AND ("health workers")	19
Web of Science http://apps.webofknowledge.com/	(("Quality of Life" OR "Health Related Quality Of Life" OR "Health-Related Quality Of Life" OR "Life Quality" OR "HRQOL") AND ("Family Health" OR "Family Health Strategy" OR "Primary Health Care") AND ("Health Occupation" OR "Health Worker" OR "Health Profession" OR "Health Personnel" OR "Occupational Health"))	14
ScienceDirect https://www.sciencedirect.com/	("Quality of Life" OR "Life Quality" OR "HRQOL") AND ("Family Health" OR "Family Health Strategy" OR "Primary Health Care") AND ("Health Occupation" OR "Health Worker" OR "Health Profession" OR "Health Personnel" OR "Occupational Health")	878
Embase http://www.embase.com	('quality of life' OR 'health related quality of life' OR 'health-related quality of life' OR 'life quality' OR 'hrqol') AND ('family health' OR 'family health strategy' OR 'primary health care') AND ('health occupation' OR 'health worker' OR 'health profession' OR 'health personnel' OR 'occupational health')	112
OpenGrey http://www.opengrey.eu/	("Quality of Life") AND ("Family Health" OR "Primary Health Care") AND ("Health Worker" OR "Health Profession" OR "Health Personnel")	0
	("Quality of Life") AND ("Family Health") AND ("Occupational Health")	0
OpenThesis http://www.openthesis.org/	("Quality of Life" OR "Health Related Quality Of Life" OR "Health-Related Quality Of Life" OR "Life Quality" OR "HRQOL") AND ("Family Health" OR "Family Health Strategy") AND ("Health Worker" OR "Health Profession" OR "Health Personnel")	55
OATD https://oatd.org/	("Quality of Life" OR "Health Related Quality Of Life" OR "Health-Related Quality Of Life" OR "Life Quality" OR "HRQOL") AND ("Family Health" OR "Family Health Strategy") AND ("Health Worker" OR "Health Profession" OR "Health Personnel")	2
TOTAL		1,744

Study selection

The studies were selected in three phases. In the first phase, as a calibration exercise, two reviewers discussed the eligibility criteria and applied them to a sample of 20% of the studies retrieved after the initial search to determine the inter-examiner agreement. After achieving a proper level of agreement (Kappa≥0.81), two reviewers (PRCP and NCA) methodically analyzed all the titles of the studies, independently. The reviewers were not blind to the names of authors and journals. Titles not related to the topic were excluded in this phase. In the second phase, the reviewers (PRCP and NCA) read the abstracts independently for the initial application of the exclusion criteria. Articles with titles that met the objectives of the study but did not have abstracts available were fully read in phase three.

In the third phase, the full texts of the preliminary eligible studies were evaluated to verify whether they fulfilled the eligibility criteria. When both reviewers disagreed, a third (LRP) was consulted to make a final decision. The studies excluded were recorded in a separate database, explaining the reasons for exclusion.

Data collection

After the selection, the studies were analyzed and two reviewers (NCA and AMH) extracted information regarding the identification of the study (author, year, and location), sample, gender, age, data collection, analysis type, health professionals investigated, and qualitative results (main codes, secondary codes, and speech analysis).

To ensure consistency among the reviewers, a calibration exercise was performed with both reviewers (NCA and AMH), in which information was extracted jointly from an eligible study. Any disagreement between the reviewers was solved through discussion and, when both reviewers disagreed, a third (LRP) was consulted to make a final decision.

Risk of bias in individual studies

The Joanna Briggs Institute Critical Appraisal Tools for use in JBI Systematic Reviews[10] for qualitative studies assessed the risk of bias and the individual methodological quality of the studies selected. Two authors (PRCP and AMH) independently assessed each domain regarding its potential risk of bias, as recommended by the PRISMA-P statement[8].

Each study was categorized according to the percentage of positive answers to the questions in the assessment tool. Risk of bias was considered *High* when the study obtained 49% of "yes" answers, *Moderate* when the study obtained 50% to 69% of "yes" answers, and *Low* when the study reached more than 70% of "yes" answers.

Meta-synthesis

The meta-synthesis was performed according to the steps indicated by Matheus et al.[11]. After identifying the eligible studies, the reviewers read all the articles to capture their meaning. All main codes and secondary codes were extracted from the studies (Chart 3) and organized by similarity, divergence, or complementarity, without losing the meaning of each study. Main or secondary codes not related to WRQoL were excluded. The last step was to elaborate a descriptive, concise, and comprehensive synthesis of new main codes.

RESULTS

Study selection

During the first phase of study selection, 1,744 results were found in the 10 electronic databases, including three gray literature databases. After removing duplicates, 1,373 articles remained

for the analysis of titles and abstracts, from which five studies were considered eligible for full-text analysis. The references of the five potentially eligible studies were evaluated carefully and one additional article was selected, resulting in six studies for full-text reading. After reading the full texts, all eligible studies were included. Finally, six studies were selected for qualitative analysis and meta-synthesis. Figure 1 describes the process for search, identification, inclusion, and exclusion of articles.

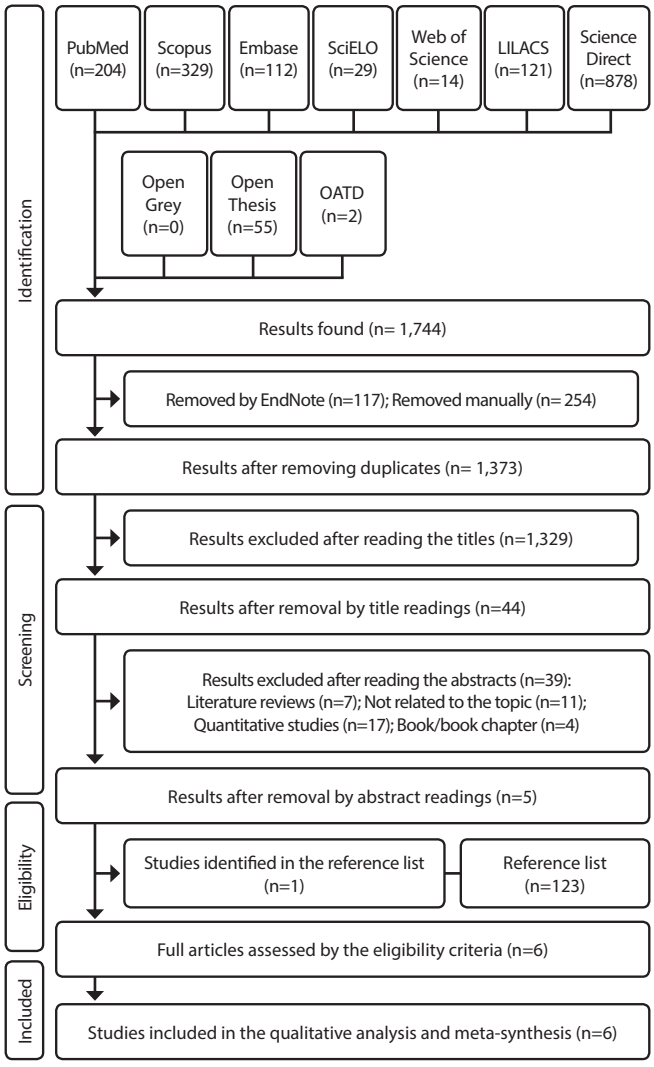

Figure 1 - Flowchart of the process of literature search and selection, adapted from the PRISMA-P statement

Characteristics of eligible studies

The studies were published from 2010 to 2017 and they were all carried out in Brazil[12-16]. The total sample included 263 Family Health Strategy (FHS) professionals. The average age ranged between 22 and 68 years old (Chart 2). Three studies[12,16-17] discussed FHS teams, while three studies[13-15] explored Family Health Support Centers (FHSC)[13-15]. All the studies[12-17] followed ethical criteria and the professionals signed informed consent forms.

The qualitative studies were conducted with interviews[12-13,16] or focus groups[14-15,17]. Regarding the research teams, one study was conducted by only one researcher[9], two studies by two researchers[12,17], one study by five interviewers previously trained and accompanied by five authors[16], and two studies did not indicate the number of evaluators in the process[14-15]. Chart 2 shows further details about the eligible articles.

Risk of bias in individual studies

All eligible studies[12-17] presented a low risk of bias. Most of the articles were assessed as having 70% of "yes" responses[12-13,16-17] and two[14-15] were assessed as having 90% of "yes" responses. The following three questions presented a high rate of negative responses: Question One (Are the philosophical perspective and the research methodology stated compatible?), Question Six (Is there a statement locating the researcher culturally or theoretically?), and Question Seven (Is the influence of the researcher on the study, and vice versa, addressed?). These three questions are important to clarify the position of the study in the philosophical and theoretical approaches, but the studies included did not address these issues.

Specific results of eligible studies and meta-synthesis

The eligible studies[12-17] contained 16 main codes and 57 secondary codes (Chart 3). One main code reported by Maia[12] (concept of quality of life) was excluded, along with its secondary codes, because it did not relate to QWL. Similarly, one main code (permanent health education) and its secondary codes, indicated by Nascimento et al.[14], were excluded. Organizing the secondary codes according to similarity, divergence, or complementarity allowed the creation of the following four new main codes that interfere with QWL: working conditions; work processes: interpersonal relationships; and personal aspects. Three subcodes (work context, work overload, and autonomy) were associated with some of these main codes. Figure 2 presents the relationship of the codes (and their related subcodes) with QWL.

Personal aspects*:* Quality of life may be negatively affected when health professionals are unmotivated, unsatisfied, or do not identify with the work. It is reasonable that motivation, satisfaction, and identification with the work have positive impacts, but other factors were identified as positive for QWL, such as adequate pay, professional requirements, and welfare.

Interpersonal relationships: Communication, respect, appreciation, and acknowledgment of work by colleagues, managers, and patients may positively affect quality of life, while their absence is damaging. Assessing the relationship between primary care teams and FHSC requires an understanding that conflicts about power and not accepting the philosophy of the FHSC may interfere negatively with quality of life.

Work processes: This main code was the one most frequently reported, and was associated with quality of life. Low resolvability, project discontinuity, lack of knowledge about the tasks required, maintenance of the outpatient model, and low numbers of collective care tools were negative factors for quality of life. Two subcodes associated with negative impact should be highlighted: work overload and population context (violence, vulnerability, and complexity). However, work processes may positively affect

Chart 2 - Summary of the main characteristics and results for the eligible studies

Author, year	State	Team type	Sample	Gender (n/%)	Age	Analysis type	Health professionals investigated
Maia et at., 2010	MG	Interview	36	F: 31; 91.18 M: 5; 8.82	20-30	Speech analysis	18 community health workers; 18 users.
Lopes et al., 2012	RS	Focus group	24	U	31-40	Speech analysis	24 community health workers.
Leite et al., 2014	SP	Interview	40	F: 31; 77.5 M: 9; 22.5	32.4*	Speech analysis	4 community health workers; 4 nutritionists; 4 physical educators; 5 psychologists; 1 pharmacist.
Bracarense et al., 2015	RJ	Interview	123	F: 114; 92.68 M: 9; 7.32	22-68	Speech analysis	12 nurses; 9 dentists; 66 community health workers; 14 nursing technicians; 10 oral health technicians.
Nascimento et al., 2016	SP	Focus group	20	U	U	Content analysis	FHSC professionals
Nascimento et al., 2017	SP	Focus group	20	U	U	Content analysis	FHSC professionals

*Note: U - Uncited; *Mean; MG - Minas Gerais; RS - Rio Grande do Sul; SP - São Paulo; RJ - Rio de Janeiro; F – Female; M – Male; FHSC – Family Health Support Center.*

Chart 3 - Summary of the main results of the eligible studies

Author, year	Main code	Secondary code
Maia et al., 2010	Concept of quality of life	Quality of life requires housing, sanitation, electricity, and health needs to be met; A long life depends on a high income; Health is a synonym for quality of life; Quality of life is associated with satisfying your subjective needs.
	Work and population's quality of life	Collective actions; Healing actions; Disease prevention and quality of life; Physical exercise; Activities to improve the quality of life of the population.
	Family health professional requires changes	Outpatient model; Lack of communication with the population; Lack of attention to users; Community health professionals believe they should have more activities related to improving quality of life.
Lopes et al., 2012	Pleasurable situations	Acknowledgment and effort at work; Possibility of working with peers; Use of creativity
	Suffering situations	Suffering from ignorance about functions; Suffering from working in a team; Obligation to live and work in the same place; Violence exposure; No appreciation of suffering.
Leite et al., 2014	FHSC infrastructure	Work resources; Lack of physical space.
	Overload and quality of life at work	Lack of institutional support; Work processes; Workload.
	Autonomy and identification with work	Resilience and growth; Personal satisfaction.
	Teamwork and interpersonal relationship	Communication; Respect; Provisions for working in a team.
Bracarence et al., 2015	Current vs. prescribed work	Difficulty of implementation; Great demand of cases; Matrix support and case studies are rarely used; Number of consultations and quality of service; Demotivation.
	Immediacy of curative culture present in professional practice	Immediacy of curative culture present in professional practice.
	Profile, overload, and job identification	Identification with the work; Work overload; Relationship with teams; Health care for professionals.
Nascimento et al., 2016	Identification of the proposal by FHSC professionals and work knowledge	One of the strengths of the professional is identifying the model proposed; Acknowledgment by patients and teams provides professionals with satisfaction and pleasure in their everyday work; Appreciation and acceptance of the FHSC as part of the FHS when a physical educator is included in the team; Autonomy and creative freedom generate pleasure in the job; The creation of educational groups for the community was also mentioned as an impact factor on the quality of life of the population; There is a dialectal perspective between the suffering and pleasure of professionals associated with disputes about power in the FHSC.
	Interdisciplinary work	Interdisciplinarity and teamwork are sources of pleasure and strength in the execution of the job; Experiences are exchanged through the relationships of workers from different areas, representing gains at work; Respect for diversity and differences in work routines are clear, and reporting on habits that may be learned and developed; Workers are happy to transcend their professional skills in the logic of interdisciplinarity.
	Permanent health education	There is appreciation, pleasure, and understanding related to permanent health education.
Nascimento et al., 2017	Acknowledgment at work	Acknowledgment and effort at work; Possibility of working with peers; Suffering from ignorance about functions; Suffering from working in a team; Obligation to live and work in the same place; Avoiding being misunderstood; No appreciation for suffering.

Note: FHSC - Family Health Support Center.

quality of life, especially when developing preventive, educational, and resolvability actions. The autonomy of professionals to work with creativity and resilience was a major subcode of the positive impact of working conditions on quality of life.

Working conditions*:* Inadequate physical space, insufficient resources, and lack of institutional support were listed as negative for quality of life. Professionals have requested changes in these working conditions, along with formal training facilities.

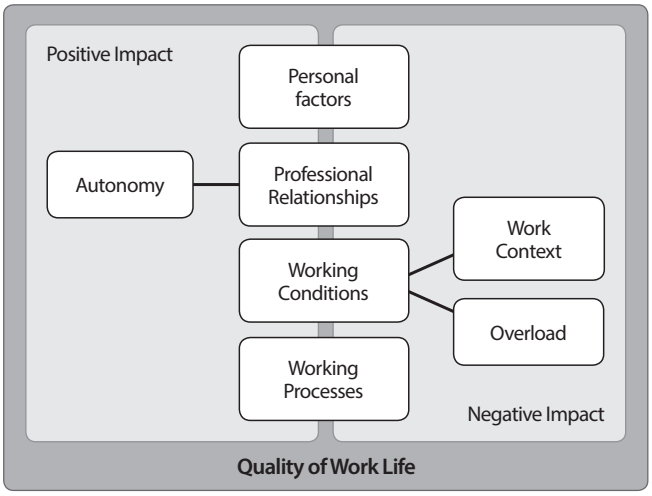

Figure 2 - Conceptual framework from the meta-synthesis of the qualitative studies included

DISCUSSION

The present systematic review and meta-synthesis of qualitative studies were developed to understand the quality of work life (QWL) of Family Health Strategy (FHS) professionals. The synthesis of codes identified in the included studies showed that personal aspects, interpersonal relationships, work processes, and daily working conditions affect QWL in the context investigated. These four aspects may represent positive or negative factors. Associated factors such as work overload and work context have a negative impact, while professional autonomy has a positive impact.

Understanding QWL is not a new scientific topic. Generic models to assess QWL dating from the 1970s include authors such as Westley[18], Walton[19], and Fernandes et al.[4]. The model presented by Westley[18] focuses on identifying problems perceived in the work environment. It consists of four dimensions of problems: political (insecurity); economic (inequity); psychological (alienation); and sociological (anomie)[18]. The model presented by Walton[19] is used the most; it includes salary, working conditions, work capacity, work opportunities, social integration, respect for work laws, and social significance. Finally, the model presented by Fernandes et al.[4] establishes that QWL results from reconciliation of the interests of employees and employers. This model is the one that is most similar to the current assessment of QWL based on the approach by Dejours, which is consolidated in the psychodynamics of work. Thus, it is worth noting that the studies by Nascimento and Oliveira[14] and Nascimento et al.[15], which are included in this meta-synthesis, used Dejours' thought as an analytic reference.

Attempts to conceptualize QWL are based on these classical models, and they incorporate aspects related to life and working conditions[20]. Hence, the concept of QWL in the FHS context found in the present meta-synthesis includes dimensions of the models of both Walton[19] (salary, working conditions, and social integration and significance) and Westley[18] (political and sociological aspects). However, the meta-synthesis highlights the autonomy of FHS professionals in healthcare planning, also showing the negative impact of social context and work overload on patients.

Current studies of QWL developed with health professionals such as surgery residents[21], pediatric residents[22], nurses[23-25], and hospital employees[26] have used the Work-Related Quality of Life (WRQoL) scale. This scale was developed specifically to measure QWL in health professionals and it consists of the following dimensions: general well-being; home/work interface; job and career satisfaction; control at work; working conditions; and stress at work[27].

Most dimensions assessed with the WRQoL were compatible with the factors associated with QWL observed in this systematic review and meta-synthesis (personal aspects, interprofessional aspects, working conditions, job and career satisfaction, and work overload). However, important QWL characteristics in the FHS (work context) were not listed, which indicated failure to use the WRQoL scale in this specific primary healthcare service. Work context is usually recognized as the social environment where interprofessional relationships and work processes are developed[16,28]. However, it is important to acknowledge that the work context of FHS professionals is not limited to health centers, but to the entire assigned territories. Thus, health professionals establish close connections to urban violence and social and family problems[16-17]. Community health workers present an aggravating factor: They work in the same place they live, which incurs loss of privacy [17]. Exposure to violence is indirectly related to reduction in QWL because it exposes health professionals to increased stress in the workplace[29].

Personal aspects, working conditions, and work processes have been included in the discussion of QWL, especially by Dejours (psychodynamics of work), who analyzed the relationship between suffering and pleasure at work. From this perspective, the promotion of QWL is achieved by transforming suffering into pleasure, especially by acknowledging the work developed[30]. Determining pleasure depends on professional resilience, which is a complex concept that aims to understand the ability to adapt to a diverse environment. Resilience presents differences related to emotional structure, self-directedness, the ability to accept uncertainty and occasional errors, personal meaning, sense of purpose, and vocation[31].

Study limitations

A limitation of this study is differences regarding the professionals investigated (physicians, nurses, community health workers, or FHSC professionals) in the studies included. Further studies with only one professional category may help to better understand what workers face at FHS.

Contributions to Nursing, Health or Public Policy

The contribution of this systematic review and meta-synthesis is that it helps to outline a new conceptual framework for investigations of quality of life among Family Health Service professionals. Based on the concept presented, further qualitative studies could

apply the dimensions verified, and new instruments to measure QWL could be developed to investigate the specific context of family health. Consequently, the study provides better guidance for public health actions, especially those aimed at FHS professionals.

CONCLUSIONS

This systematic review and meta-synthesis verified factors (or dimensions) that should be considered in investigations of the quality of work life (QWL) of Family Health Strategy (FHS) professionals. These factors are working conditions, work processes, interpersonal relationships, personal aspects, work context, work overload, and autonomy. This study confirms that most aspects commonly investigated for QWL of health professionals agree with factors indicated in the present systematic review and meta-synthesis. However, the QWL of FHS professionals presents particularities related to work context, which is presented as negative for QWL.

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