DOI: 10.1590/1413-81232020254.22072018

Burnout Syndrome in Family Health Strategy Managers

Alice Mariz Porciuncula (http://orcid.org/0000-0002-2994-8327) [1]
Sandra Aparecida Venâncio (http://orcid.org/0000-0002-1439-2960) [1]
Cosme Marcelo Furtado Passos da Silva (https://orcid.org/0000-0001-7789-1671) [1]

Abstract *This paper analyzed the Burnout Syndrome (BS) among the managers of the Family Health Strategy (ESF) in the city of Rio de Janeiro and its associations with factors that influence the presence/absence of BS among these professionals. This is a descriptive study that used data from a questionnaire consisting of two parts: 1) manager profile and factors that could influence the presence of Burnout; 2) Maslach Burnout Inventory. The return rate was 63.5% (143) of the 225 questionnaires sent. The ESF managers are generally nurses (68.6%), young (63.6% under 39 years) female (76.9%), who have acted as managers for less than 5 years (85.2%). A BS presence was identified in 11.2% of the managers. The factors of an organizational nature were those that obtained the highest number of variables with an association. These data point to the need to make changes in the organizational practices of services and changes in work processes. Further studies on these issues can contribute to this.*

Key words *Burnout, Primary Health Care, Health Manager*

[1] Escola Nacional de Saúde Publica Sérgio Arouca, Fundação Oswaldo Cruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. alicemarizpresf@gmail.com

Introduction

This study analyzed the presence of Burnout Syndrome (BS) among the managers of the Family Health Strategy (ESF) in the city of Rio de Janeiro. The position of professional manager was established in the Municipality as part of the of Primary Health Care (PHC) Management Model Reform conducted by the Municipal Health Secretariat (SMS) in 2009[1] through the incorporation of management contracts between the SMS and Social Organizations[2,3]. The manager must coordinate the means and processes, so the organization fulfills its purpose[4]. It differs from the role of the health manager, who is in charge of directing the health system in the different spheres of government[5].

The advancement in the conceptual distinction between these functions has not been accompanied by clear definitions of the role and attributions of managers[6], although their activity is essential for the health production process[7]. Besides the strong pressure for short-term results, low salaries and insufficient numbers of professionals, the development of this function can lead to frustration, anguish, failure and exhaustion, leading to physical illness[8].

Among other aspects, chronic work stress due to disillusionment, discouragement and intense frustration with work, in which the worker, who was previously extremely involved with the service and with clients, loses energy and gives up, is one of the main characteristics of the BS[9]. Its presence among workers can influence the quality of care provided[10-12], since well-being and professional satisfaction are important factors for professionals to perform their functions more efficiently.

Maslach et al.[13] are among the authors who have studied Burnout syndrome with great frequency. They believe that this syndrome stems from the presence of three elements: emotional exhaustion, depersonalization and low professional achievement[13].

Emotional exhaustion is its most obvious manifestation, involving organizational and individual factors. It is a response to chronic stress caused by work, which accompanies the feeling of not having the emotional resources to address stressful situations[13,14].

Depersonalization is associated with the professional's emotional hardening, demonstrated through cynicism, indifference and irony towards the subject with or for whom one acts, as a way of avoiding involvement with people[13,14].

The declining professional achievement is related to disbelief in the value of their work activity, low self-esteem, dissatisfaction and demotivation, referring to the negative self-assessment of professionals regarding the quality of the work performed. The subjects become unhappy with themselves and dissatisfied with their achievements at work[14,15].

Besides the personal characteristics, aspects related to poor working conditions, due to the recent transformations in the world of work, expressed among other aspects by the productive restructuring, mass layoffs, precariousness and increasing demands of workers are described as the main determinants of the Syndrome[13].

In some countries, the diagnosis of Burnout allows the worker to receive financial compensation, as well as counseling, psychotherapy and rehabilitation. In others, however, the condition is not recognized as a work-induced disease[16]. In Brazil, the Ministries of Health and Social Security consider the BS as a work-related occupational disease[17,18]. However, as Zorzanelli et al.[19] points out, it remains hardly known in the medical and social security spheres.

Recent studies on the presence of BS in the ESF identified their presence among Community Health Workers (29.3%)[20] and PHC professionals (7%)[21] in the city of Aracaju, Sergipe.

Our study seeks to identify factors associated with the development of BS among the managers of the ESF of the Municipality of Rio de Janeiro and would contribute to the reflection on the position of manager and the processes in which he/she is involved. Thus, we are led to think of new ways to prevent and take care of the sickness of this professional, as well as its consequences.

Methods

This is a cross-sectional, descriptive study carried out in the entire territory of the city of Rio de Janeiro with managers working in health facilities with ESF in the municipality at the time of their development, excluding those working in health facilities without the presence of the ESF, as well as those who did not respond to the questionnaire.

The questionnaire used consisted of two parts: one containing questions aimed at outlining the profile of the interviewed managers and identifying factors that could influence the presence or absence of the BS, and another containing the Maslach Burnout Inventory (MBI).

Ciência & Saúde Coletiva, 25(4):1555-1565, 2020

The first part consisted of 39 questions regarding the personal and professional characteristics of the participants (age, gender, marital status, children, profession, working in another job, qualification, length of service, personality, appearance of symptoms), those of the facilities (number of teams, presence of another manager, physical conditions, frequency of conflicts and presence of armed violence in the work territory) and possible triggering or protective Burnout agents (deadlines, responsibilities, community expectations, demands, workload, working outside work hours, valorization, stability, ascension, remuneration, institutional support, autonomy, instruments of support and respect for decision-making). These variables were chosen considering the possible relationship with the BS shown in several studies on the subject[13,14,22].

MBI, the second part of the questionnaire, was created by Maslach and Jackson[15] in 1981 to evaluate the BS. This scale was chosen because of its extensive use in studies on the subject in the world and because it is a material already validated in Brazil. Approximately 90% of BS studies used MBI or some adapted versions of the MBI[14].

The Scale contains three realms to evaluate the relationship of workers with their work: *Emotional Exhaustion* (9 questions), *Professional Realization* (8 questions) and *Depersonalization* (5 questions). For its use in the research, the questionnaire validated by Tamayo and Tróccoli[10] was adopted. This instrument contains 22 questions, with 5 possible answers, as follows: "Never" – 1 point, "Sometimes in the year" – 2 points, "Sometimes in the month" – 3 points, "Sometimes in the week" – 4 points and "Daily" – 5 points. The psychometric properties of the scale have a satisfactory internal consistency of the three realms, presenting a Cronbach's alpha ranging from 0.71 to 0.90[23]. Thus, the score attributed to each varied between the realms according to the number of questions and the score assigned by each respondent to the questions: Emotional Exhaustion (9 to 45); Professional Achievement (8 to 40) and Depersonalization (5 to 25).

As the inventory creators guide, we evaluated each realm individually[15]. Statistically, cut-off points were set as "low", "moderate" and "high", based on the low, medium and high tertiles of the score distribution, as recommended by the MBI manual[16], described in Table 1.

The questionnaires were distributed face-to-face or online submission. The online version, identical to the paper questionnaire, was built with Google Drive and aimed to increase the participation of the target audience, given the difficulty observed among the managers of making time available for completion. Telephone contacts with managers and the resubmission of the questionnaires were made up to four times to reduce losses. At the time of the survey, 225 ESF managers were operating the Municipality of Rio de Janeiro, and the instrument was forwarded to all. The return was 63.5%, that is, a total of 143 participants.

SPSS was the software used to analyze the data, distributed in a table with frequencies (absolute and relative) and in summary measures (minimum, maximum, mean, standard deviation, variance and coefficient of variation). Associations were assessed using the Chi-square independence test (c^2) and, when necessary, Fisher's exact test. A significance level of 5% was adopted. Because it is not a probabilistic sample, we do not intend to generalize the findings of this study, but only to test the association between the variables in the sample.

The study was submitted to and approved by the Research Ethics Committees of the Sérgio Arouca National School of Public Health (ESNP) and the Municipal Health Secretariat of Rio de Janeiro, and the consent form was shown to and signed by the participants.

Results

The managers of the ESF facilities are generally young people under 39 years of age (74.5%), female (76.9%), almost half is married (49.7%) and most have children (53.8%). Nursing is the prevailing profession (68.6%) and the work as a manager is the only employment relationship (73.4%). The experience with management is recent, between 2 and 5 years (50%), and 35.2% have been engaged in this activity for less than two years, and 55.9% work in an area experiencing armed violence (Table 2).

The presence of the BS, where the individual shows the three realms at a critical level[14,23], was identified in 11.2% of the managers.

Table 3 shows the findings regarding each BS realm found among the participants. Of these, 29.4% showed the emotional exhaustion dimension at a high level, 25.2% depersonalization at high levels and 32.8% professional achievement at a critical level.

Contrary to other studies that perform data cross-referencing between variables and realms separately, we have chosen a linear combination

Table 1. Cut-off points for diagnosis of the Realms of Burnout Syndrome by tertiles identified.

Realms	Questions	Level		
		Low	Medium	High
Emotional Exhaustion	1, 2, 3, 6, 8, 13, 14 16 and 20	< 24	24-31	> 31
Depersonalization	5, 10, 11, 15 and 22	<9	09-12	> 12
Professional achievement	4,7, 9, 12, 17, 18, 19 and 21	< 32	32-35	> 35

Table 2. Absolute and proportional distribution of ESF managers by Profile.

	n*	%
Age	141	100.0
20-29 years	30	21.3
30-39 years	75	53.2
40-49 years	23	16.3
50 or more years	13	9.2
Did not reply	2	-
Gender	143	100.0
Female	110	76.9
Male	33	23.1
Marital status	143	100.0
Married	71	49.7
Divorced	16	11.2
Single	55	38.4
Widowed	1	0.7
Children	143	100.0
Yes	77	53.8
No	66	46.2
Profession	137	100.0
Nurse	94	68.6
Dentist	16	11.7
Social worker	7	5.1
Nutritionist	6	4.4
Physiotherapist	5	3.6
Psychologist	3	2.2
Pharmacist	2	1.5
Doctor	2	1.5
Speech therapist	1	0.7
Biologist	1	0.7
Did not reply	6	-
Has another job	143	100.0
No	105	73.4
Yes	38	26.6
Length of service in management		
< 2 years	50	35.2
2 years to < 5 years	71	50.0
5 years or more	21	14.8
Working in an armed violence area	143	100.00
No	63	44.1
Yes	80	55.9
Sim	80	55,9

*Absolute number.

Table 3. Absolute and proportional distribution regarding the Realms of Burnout Syndrome found in ESF managers.

		n	%
Emotional Exhaustion	Low	48	33.6
	Moderate	53	37.0
	High	42	29.4
Depersonalization	Low	48	33.6
	Moderate	59	41.2
	High	36	25.2
Professional achievement	Low	47	32.8
	Moderate	50	35.0
	High	46	32.2

with the results regarding the presence/absence of Burnout, since we intend to identify possible explanations for the syndrome in its total context. The explanatory variables were clustered into common themes to facilitate reading and understanding, as follows: individual characteristics, characteristics of health facilities and organizational characteristics. In Table 4, we show those in which we find an association.

Concerning the individual characteristics, the variables were: age, sex, marital status, children, profession, presence of another job, professional experience, qualification, personality (overly involved, idealist, controlling and competitive), presence of symptoms after assuming the position and the three most commonly found symptoms (anxiety, insomnia and blood pressure problems).

There was an association between age ($p = 0.043$), anxiety ($p = 0.019$) and the "overly involved" personality ($p = 0.050$). The syndrome was present among young managers (under 40 years) and among those reporting the onset of anxiety after taking office, a fourth evidenced BS. Approximately 30% were identified with BS among those who did not consider themselves overly involved, while only 9.8% presented Burn-

Table 4. Explanatory variables associated with Burnout Syndrome in ESF managers.

			Total		Without Burnout		With Burnout		P
			n	%	n	%	N	%	
Individual	Age group	20-29 years	30	21.3	25	83.3	5	16.7	0.043
		30-39 years	75	53.2	64	85.3	11	14.7	
		40 years or more	36	25.5	36	100.0	0	0.0	
	Showed symptoms of anxiety after assuming managerial position	Yes	24	26.1	18	75.0	6	25.0	0.019
		No	68	73.9	109	91.6	10	8.4	
	Considers himself/herself an overly involved professional	Yes	133	93.0	120	90.2	13	9.8	0.050
		No	10	7.0	7	70.0	3	30.0	
Characteristics of facilities	Experiences conflicts	Occasionally/rarely/ never	48	33.6	47	97.9	1	2.1	0.014
		Always/frequently	95	66.4	80	84.2	15	15.8	
	Works in an area with the presence of armed violence	Yes	80	55.9	66	82.5	14	17.5	0.007
		No	63	44.1	61	96.8	2	3.2	
Organizational characteristics	Considers number of demands requested as per responsiveness	Well below/below/as per responsiveness	67	46.9	66	98.5	1	1.5	0.001
		Well above/above	76	53.1	61	80.3	15	19.7	
	Considers number of responsibilities as per responsiveness	Below/as per responsiveness	70	49.0	67	95.7	3	4.3	0.010
		Well above/above	73	51.0	60	82.2	13	17.8	
	Considers deadlines required as sufficient	Occasionally/rarely/ never	114	79.7	98	86.0	16	14.0	0.032
		Always/frequently	29	20.3	29	100.0	0	0.0	
	Has autonomy in decision-making	High/total	79	55.3	76	96.2	3	3.8	0.002
		Partial/No	64	44.7	51	79.7	13	20.3	
	Deems support instruments as	Insufficient/not available	87	60.8	72	82.8	15	17.2	0.004
		Sufficient/indifferent	56	39.2	55	98.2	1	1.8	
	It is supported institutionally by the contracting social organization	Occasionally/rarely/ never	54	37.8	44	81.5	10	18.5	0.030
		Always/frequently	89	62.2	83	93.3	6	6.7	
	Feels supported institutionally by the Coordination Office of the Programmatic Area (local territorial support)	Occasionally/rarely/ never	45	31.5	32	71.1	13	28.9	<0.001
		Always/frequently	98	68.5	95	96.9	3	3.1	
	Trusts the Social Organization	Occasionally/rarely/ never	36	25.2	28	77.8	8	22.2	0.015
		Always/frequently	107	74.8	99	92.5	8	7.5	
	Trusts the Coordination Office of the Programmatic Area (local territorial support)	Occasionally/rarely/ never	41	28.7	31	75.6	10	24.4	0.001
		Always/frequently	102	71.3	96	94.1	6	5.9	
	Feels valued	Occasionally/rarely/ never	94	65.7	78	83.0	16	17.0	0.002
		Always/frequently	49	34.3	49	100.0	0	0.0	
	Believes in the possibility of career advancement	Partially/no	111	77.6	95	85.6	16	14.4	0.023
		Yes	32	22.4	32	100.0	0	0.0	

out among those who considered themselves overly involved.

Regarding the characteristics of the facilities, the following variables were used: number of teams, the presence of another manager, physical conditions, the experience of conflicts and presence of armed violence in the work territory. A relationship was found only between the last two: the experience of conflicts ($p = 0.014$) and presence of armed violence ($p = 0.007$).

The conflict situation is experienced (often/always) by 66.4% of the managers. Of these, 15.8% evidenced BS, which was seven times higher than those who did not experience conflict at the same frequency. The percentage of BS among those managers who worked (often/always) in areas marked by armed violence (55.9%) was 17.8% and of 3.2% among those who did not work.

The following variables were tested in the organizational characteristics: deadlines, responsibilities, demands, valuation, ascension, institutional support, autonomy, support tools, community expectation, respect for decision making, workload, work beyond working hours, stability and remuneration. Only the last four variables were not associated with BS.

There was a more significant presence of Burnout in the group of managers who found that demands and responsibilities required are above/far above their capacity to respond and in those who consider the deadline for the tasks to be insufficient.

Most of the managers (55.3%) identified a great deal of professional autonomy to carry out their work, which is an essential aspect for the professional to work satisfactorily. Among these, the BS was 3.8%; among those who believe that they do not have autonomy or describe it as partial, the presence of BS was 20.3%. Managers feel (often/always) supported by management – 62.5% by Social Organizations (OS) and 68.5% by the Planning Coordination Office (CAP) – and trust in these organizational levels (74.8% % in the OS and 71.3% in the CAP). The presence of the Syndrome was lower in these groups than among those who do not feel supported/do not trust.

Large associative impacts were found regarding professional valuation. No cases of BS were found in the group that always/frequently feels valued. In contrast, all cases of the disease were among those who never, rarely or occasionally feel valued.

Only 22.4% of the participating managers believe in the possibility of professional advancement, of which none developed the Syndrome.

Discussion

The presence of BS can vary according to the definition/methodology adopted. In this study, based on the definition of Ramirez et al.[23], the percentage of 11.2% was found, similar to that observed in other studies on Brazilian PHC. Trindade et al.[24] identified the percentage of 6.9% Burnout among ESF professionals in Santa Maria (RS); Silveira et al.[25] found 18% among the PHC workers in Porto Alegre (RS)[25]. Silva et al.[21] observed 7% of professionals in the PHC network with BS, and Poletto et al.[26] identified 9.5% of Burnout among municipal health managers in the state of São Paulo. These findings lead us to suppose that the rates found in ESF managers of Rio de Janeiro may be above the national average for this level of health care.

However, the existence of several scales to identify the syndrome and indications of cut-off points makes this comparison difficult. Also, no national and international studies on Syndrome among PHC managers were identified.

It is also necessary to understand the effects of BS presence among the managers for the operation of the ESF. The lack of energy to fulfill their tasks and generate the necessary results compromises work, which often ends up leading these managers to take leave or abandon the service, increasing turnover in managerial positions. Also, people with Burnout can negatively influence the work environment, causing conflicts and hindering the development of tasks[13].

Regarding explanatory variables, few personal characteristics were associated with BS. Our findings reinforce Maslach et al.'s argument[13] that describes Burnout as a more social than an individual phenomenon.

One of the few variables with a positive association, age is pointed out in the literature as an essential aspect in the onset of BS[13,27]. The existence of BS in relatively young people, such as we have found, is explained in studies because of the worker's little experience in this age group. Besides possible insecurity, it is common for young people to have great idealism, as well as anxieties and desires, which generate high expectations about work. However, the reality found hinders these expectations, bringing frustration, stress and discouragement[13,24].

There is still no consensus in the literature regarding the link between BS and gender. Some studies report a higher frequency in men and others in women[13]. No relationship between BS and gender was identified in this study. Likewise,

we also did not find any association between BS and profession. A similar result had already been described by Trindade et al.[24]. This data may indicate that the syndrome may be more associated with the attributions exercised in the managerial position than with its formation.

Although several authors[13,27] point out that the existence of more than one work relationship may increase the probability of developing BS, by increasing overload, no such relationship was found in this study. Thus, as in the study of Trindade et al.[24], no association was found between PHC length of service and the emergence of BS.

Although the qualification of health management professionals is indispensable to operate complex systems such as the Unified Health System[4], we did not identify an association between the qualification and presence of BS in managers, which does not rule out its relevance, since the lack of qualification possibly impairs the effectiveness of professionals. As Maslach et al.[13] point out, the workload is unbalanced not only when there are many tasks to be fulfilled, but also when the worker does not have the necessary qualities to perform a particular service. The level of involvement of professionals with work is described in the literature as a factor that influences the presence/absence of BS. In general, workers who evidence in their personality characteristics of greater involvement, with extreme dedication, motivated by their ideals end up overworking, often coming to exhaustion and are disappointed when they do not achieve the expected results[13,28]. Our findings do not corroborate with this vision; among the managers who consider themselves to be overly involved, the percentage of BS identified is significantly lower than among those who did not identify themselves as such. The reasons for this difference should be better understood by other studies.

The association between anxiety and BS identified in this study deserves attention on the part of the worker's health. Many managers identify their appearance after assuming the position of ESF managers, which leads us to two hypotheses: anxiety could induce illness due to burnout, or among the symptoms brought about by BS, in the ESF managers, anxiety can be the most frequent symptom. However, Maslach et al.[13] show that the presence of the Syndrome can lead to the development of mental health-related problems, among them anxiety. Regarding the characteristics of the facilities, we find a connection with the BS in only two points: the experience of conflicts and the presence of armed violence. The physical conditions were not shown to be linked to the BS, as well as the type of facility, number of teams and the presence of another manager or director.

Conflict often produces negative feelings of frustration and hostility and reduces the possibility of social support[13]. The feeling of insufficiency brought about by this type of event possibly triggers emotional instability and a self-perception of impotence, causing these professionals to minimize empathy by users as a type of defense, thus configuring the Syndrome. Data combination in this study confirmed the connection of this variable with BS.

In the case of Rio de Janeiro's PHC, considering the principle of equity, many teams attend areas of significant social vulnerability with the constant presence of armed individuals. Work in these territories often exposes workers to violence, resulting in the suspension of the programmed activities, which triggers in the professionals the feeling of not performing the service correctly[28]. This difficulty experienced by PHC workers was described by Polaro[29].

This scenario compromises the physical and mental health of these workers, besides leading them to feelings of fear, anxiety, impotence and frustration. Lancman et al.[29] adds that faced with armed violence, professionals feel exposed, and fearing for their physical integrity, are concerned about possible reprisals and lament the invisibility of their efforts. This set of factors may explain the relationship between BS in ESF managers and the presence of armed violence in the territory of action found in this study.

It is worth noting that although many teams work in a territory with armed violence in the country, studies are still rare. It was not possible to locate papers that studied the relationship between the presence of armed violence and the existence of the Syndrome, possibly because the countries that have been studying BS for a longer time do not coexist with this experience.

Organizational characteristics were those with the highest association with BS, corroborating the view of Maslach et al.[13]. This is because the organization expects the employee to devote increasingly more time, effort, talent and flexibility to work without having to secure adequate career opportunities, stability and security[13] reciprocally.

Among the organizational variables, the weekly workload and the uncontracted work beyond working hours were not associated with BS. However, according to Schaufeli et al.[16], these factors would be linked to the BS, since not having

sufficient time to rest and regenerate the reduced energy aggravates the impact of exhaustion generated by the imbalance between demand and available resources.

The managers' perception that deadlines are not always enough to carry out the proposed tasks is echoed in the study by Maslach et al.[13], who affirm that the pressure for meeting deadlines is strongly and consistently associated with BS. The excessive demand and responsibility beyond their ability, on a routine basis, contributes to the professionals developing a sense of incompetence[13,28]. This explains the association identified between Burnout and ESF managers who consider the deadlines insufficient and the demands and responsibilities beyond their ability.

The relationship between the syndrome and the lack of management tools available to support the work can be explained according to Maslach et al.[13] because of the excess efforts to perform the tasks, which induces professionals' exhaustion. Likewise, the association with the lack of autonomy found in this study is also shared by Trigo et al.[27], who considers this variable as one of the explanatory factors of high Burnout rates. Workers feel that they have a great responsibility, but they do not have the authority to take the actions they deem effective, leading to a feeling of inability to generate the results that are demanded of them and a feeling of incompetence[13].

According to Feliciano et al.[30], there is a direct relationship between organizational support and BS. This association was shown in this study in the combination of data. Our attention was drawn to the fact that the level of confidence in their supporters is low among BS-affected participants. In this case, the lack of trust in institutional support can have an opposite effect to which it is proposed, generating exhaustion, coldness and professional dissatisfaction. According to Maslach et al.[13], the support of supervisors is especially more important than the team's support. Trigo et al.[27] reports that when organizational support is deficient, it causes feelings of helplessness, mistrust, disorientation and disrespect.

On the other hand, the low presence of Syndrome among professionals who feel supported may indicate that institutional support provided on a regular basis can generate trust, and possibly serve as a protective factor against BS for managers. Benevides-Pereira[14] say that the existence of people with whom one can count, trust and reflect in the occupational environment has been shown by several studies as a possible way of coping with BS.

In the same way, professional appreciation and the possibility of professional advancement are essential for the development of good work. Their absence leads professionals to high turnover in the labor market[13,31] and the increased probability of developing emotional exhaustion and depersonalization[31]. These findings are similar to those identified in this study, where Syndrome was more present among those managers who did not consider themselves valued and did not believe in the possibility of professional growth.

The lack of association between job stability and BS is worth mentioning because they are stress-generating elements. One possible explanation is the contradiction that the existence of special contracts entails for the public sector. According to Victora et al.[32], while these contracts facilitate the admission and dismissal of employees, they allow more competitive remunerations vis-à-vis the labor market.

The Municipality of Rio de Janeiro, through a partnership established with the Social Organizations, pays the outsourced PHC professionals a higher salary than the one received by public servants[33]. We hypothesize that this fact can generate compensation for the situation of instability, equalizing the weight of these variables and limiting their effects on the explanation of the factors identified by the managers for the onset of the syndrome.

On the other hand, there is a feeling that the salary of the manager is not fair given the complexity and social relevance of the position, as well as compared to the salary of other professionals such as doctors, who are responsible for smaller territories and population size. Such a wage discrepancy deviates from the law of the market, where greater professional competence generates more significant financial investment for its payment[6]. This feeling of injustice between unequal workload and compensation is pointed out by Maslach et al.[13] as one of the factors that contribute to the Syndrome.

The associated variables were mostly related to organizational issues, indicating the need for municipal management to develop measures that can minimize these problems, to ensure the physical and mental health of its managers and promote their engagement and satisfaction with work[12,34], thus reducing the possibility of professionals developing Burnout[35].

To this end, it is necessary to reorganize the work process to adjust the work volume to the workload and encourage the establishment of a

cooperative and creative work environment, with fair and adequate rewards and recognition mechanisms, so that professionals feel valued and satisfied[7,13].

Family Health Strategy managers are immersed in a territory that produces and reproduces relationships of power and production of subjects, which requires these professionals to understand the political, social and cultural processes of their territory. This poses several conflicts to these professionals, including ideological ones[36], often causing suffering and dissatisfaction, because of the dissonance between expectations and the reality imposed by the organization of work.

In this context, the permanent provision of training processes is a fundamental mechanism, since it enables professionals to produce together a reflection and new meanings for work, in its complexity and contradictions, which can contribute to the more integrated management and greater professional engagement[12,34].

These issues cannot be understood dissociated from the effects of the transformations of the world of work on health work, marked by the precariousness of the ESF labor relationships and, according to several authors[37,38], its most visible face is in the weak employment links and changes in the organization and the meaning of work.

Given this, it is suggested that further studies be performed to understand the syndrome in this specific group better. An essential aspect of this process is to understand the consequences of armed violence in the territory on the health of ESF professionals and health practices since they are not dissociated from the way society reproduces[38]. These efforts could support the implementation of prevention measures and the development of an intervention plan for those already affected by Burnout.

Finally, the limitations of this study should be emphasized: the first one concerns the difficulty of comparing the results found with the literature, either by the way the authors chose to show data, displaying only results referring to the BS realms, or by the variety of existing scales for the identification of the syndrome, or even the variation between cut-off points. Failure to identify studies performed with ESF/PHC managers also hindered comparisons.

Another limitation refers to respondents, as only 63.5% of the managers answered the questionnaire. It may be that those who feel healthy have not had an interest in participating in the research because they did not see benefits in their participation, which may have influenced the research results. Finally, sectional studies are portraits of the moment, not allowing the understanding of Syndrome behavior over time.

Collaborations

AM Porciuncula worked on the conception and final writing. SA Venâncio worked on the conception and final writing. CMFP Silva worked on the methodology, results and final writing.

References

1. Portela GZ, Ribeiro JM. A reforma da Atenção Primária à Saúde e a utilização dos serviços ambulatoriais no município do Rio de Janeiro (RJ), Brasil. *Saúde Debate* 2016; 40(111):34-48
2. Soranz D, Pinto LF, Penna GO. Eixos e a Reforma dos Cuidados em Atenção Primária em Saúde (RCAPS) na cidade do Rio de Janeiro, Brasil. *Cien Saude Colet* 2016; 21(5):1327-1338.
3. Bloise MS. *Os Gerentes de Unidades Básicas de Saúde do município do Rio de Janeiro: perfil, vivências e desafios*. [dissertação]. Rio de Janeiro; Escola Nacional de Saúde Pública; 2015.
4. Pêssoa L, coordenadora. *Manual do Gerente: desafios da média gerência na saúde*. ENSP. Rio de Janeiro, 2011.
5. Brasil. Ministério da Saúde (MS). *Norma operacional básica do Sistema Único de Saúde/NOB-SUS 96*. Brasília: MS; 1997.
6. Ximenes Neto FRG, Sampaio JJC. Gestores do território na Estratégia Saúde da Família: análise e perfil de necessidades de qualificação. *Rev Bras Enferm* 2007; 60(6):587-595.
7. Mesquita DT, Ximenes Neto FRG, Moreira ACA. Satisfação profissional do gerente na ESF. *Rev Adm Saude* 2013; 15(59):63-70.
8. Organização Pan-Americana da Saúde (OPAS). *Renovação da Atenção Primária em Saúde nas Américas: documento de posicionamento da Organização Pan–Americana da Saúde/Organização Mundial da Saúde (OPAS/OMS)*. Washington: OPAS; 2007.
9. Codo W, Vasques-Menezes I. O que é Burnout. In: Codo W, organizador. *Educação: carinho e trabalho*. Petrópolis: CNTE; 1999. p. 237-254.
10. Tamayo MR, Tróccoli BT. Exaustão emocional: Relações com a percepção de suporte organizacional e com as estratégias de coping no trabalho. *Estudos Psicol* 2002; 7(1):37-42.
11. Albuquerque FJB, Melo CF, Araujo Neto JL. Avaliação da síndrome de burnout em profissionais da Estratégia Saúde da Família da capital paraibana. *Psicologia Reflexão Critica* 2012; 25(3) 542-549.
12. Barroso SM, Guerra ARP. Burnout e qualidade de vida de agentes comunitários de saúde de Caetanópolis (MG). *Cad Saude Colet* 2013; 21(3):338-345.
13. Maslach C, Schaufeli WB, Leiter MP. Job Burnout. *Annual Review Pscycol* 2001: 52:397-422
14. Benevides-Pereira AMT. O processo de adoecer no trabalho. In: Pereira AMB organizador. Burnout: Quando o trabalho ameaça o bem-estar do trabalhador. São Paulo: Casa do Psicólogo; 2002. p. 21-91
15. Maslach C, Jackson SE. The measurement of experienced burnout. *J Occup Behavior* 1981; 2:99-113.
16. Schaufeli WB, Leiter MP, Maslach C. Burnout: 35 years of research and practice. *Career Development International* 2008; 14(3):204-220.
17. Moreno FN, Gil GP, Haddad MCL, Vannuchi MTO. Estratégias e intervenções na Síndrome de Burnout. *Rev Enferm UERJ* 2011; 19(1):140-145.
18. Brasil. Ministério da Saúde (MS). Organização Pan -Americana da Saúde no Brasil (OPAS). *Doenças relacionadas ao trabalho: manual de procedimentos para os serviços de saúde.* Brasília: MS; 2001. (Série A. Normas e Manuais Técnicos; n.114).
19. Zorzanelli R, Vieira I, Russo JA. Diversos nomes para o cansaço: categorias emergentes e sua relação com o mundo do trabalho. *Interface (Botucatu)* 2016; 20(56):77-88.
20. Mota CM, Dosea GS, Nunes PS. Avaliação da presença da Síndrome de Burnout em Agentes Comunitários de Saúde no município de Aracaju, Sergipe, Brasil. *Cien Saude Colet* 2014; 19(12):4719-5726.
21. Silva SCPS, Nunes MAP, Santana VR, Reis FP, Machado Neto J, Lima SO. A síndrome de burnout em profissionais da Rede de Atenção Primária à Saúde de Aracaju, Brasil. *Cien Saude Colet* 2015; 20(10):3011-3020.
22. Carlotto MS, Câmara SG. Análise fatorial do Malasch Burnout Inventory (MBI) em uma amostra de professores de instituições particulares. *Psicol Estudos* 2004; 9(3):499-505.
23. Ramirez AJ, Graham J, Richards MA, Cull A, Gregory WM. Mental health of hospital consultants: the effects of stress and satisfaction at work. *Lancet* 1996; 347:724-728
24. Trindade LL, Lautert L, Beck CLC, Amestoy SC, Pires DEP. Estresse e síndrome de burnout entre trabalhadores da ESF. *Acta paul Enferm* 2010; 23(5): 684-689.
25. Silveira SLM, Câmara SG, Amazarray MR. Preditores da Síndrome de Burnout em profissionais da saúde na atenção básica de Porto Alegre/RS. *Cad Saude Colet* 2014; 22(4):386-392.
26. Poletto NA, Probst LF, Oliveira TL, Guerra LM, Ambroosano GMB, Cortellazi KL, Gil-Monte PR, Possobon RF. Síndrome de Burnout em gestores municipais da saúde. *Cad Saude Colet* 2016; 24(2):209-215.
27. Trigo TR, Teng CT, Hallar JEC. Síndrome de Burnout ou estafa profissional e os transtornos psiquiátricos. *Rev Psiq Clin* 2007; 34(5):223-233.
28. Polaro SHI, Goncalves LHT, Alvarez AM. Enfermeiras desafiando a violência no âmbito de atuação da ESF. *Texto Contexto Enferm* 2013; 22(4):934-942.
29. Lancman S, Ghirardi MIG, Castro ED, Tuacek TA. Repercussões da violência na saúde mental de trabalhadores do Programa Saúde da Família. *Rev Saude Publica* 2009; 43(4):682-688
30. Feliciano KVO, Kovacs MH, Sarinho SW. Burnout entre médicos da Saúde da Família: os desafios da transformação do trabalho. *Cien Saude Colet* 2011; 16(8):3373-3382.
31. Sa AMS, Martins-Silva PO, Funchal B. Burnout: o impacto da satisfação no trabalho em profissionais de enfermagem. *Psicol Soc* 2014 26(3): 664-674.
32. Victora CG, barreto ML, Leal MC, Monteiro CA, Schimidt MI, Paim JS, Almeida CM, bastos FIPM, Bahia L, Travassos CMR, Reichenheim M, Barros FC. Condições de saúde e inovações nas políticas de saúde no Brasil: o caminho a percorrer. *Lancet* 2011; 6:90-102.

33. Magnago C, Pierantoni CR. Dificuldades e estratégias de enfrentamento referentes à gestão do trabalho na Estratégia Saúde da Família, na perspectiva dos gestores locais: a experiência dos municípios do Rio de Janeiro (RJ) e Duque de Caxias (RJ). *Rev Saude Debate* 2015; 39(104):9-17.
34. Porto-Martins PC, Basso-Machado PG, Benevides -Pereira AMT. Engagement no trabalho: uma discussão teórica. *Fractal Rev Psicol* 2013; 25(3):629-644.
35. Hoppen CMS, Kissman N, Chinelato JR, Coelho VP, Wenczenovicz C, Nunes FCL, Friedman G. Alta prevalência de síndrome de burnout em médicos intensivistas da cidade de Porto Alegre. Rev Bras Ter Intensiva 2017; 29(1):115-120.
36. Ximenes Neto FRG, Sampaio JJC. Análise do processo de trabalho dos gerentes no território da Estratégia Saúde da Família. *Rev Gerenc Polit Salud Bogotá (Colombia)* 2012; 11(22):76-91.
37. Rizzo TP, Lacaz FAC. Limites dos planos de cargos, carreiras e salários para desprecarização das relações de trabalho no SUS. *Trabalho Educ Saude* 2017; 15(2):399-420.
38. Schimith MD, Brêtas ACP, Simon BS, Brumd JT, Alberti GF, Bidó MLD, Gomes TF. Precarização e fragmentação do trabalho na Estratégia de Saúda da Família: impactos em Santa Maria (RS). *Trabalho Educ Saude* 2017; 15(1):163-182.

Article submitted 21/03/2017
Approved 05/09/2018
Final version submitted 07/09/2018