Dossier

Professional insertion and sanitary identity: experience of collective health alumni from ufmt, Brazil

Inserção profissional e identidade sanitarista: experiência de egressos da graduação em saúde coletiva/UFMT, Brasil

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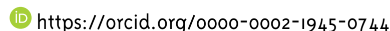
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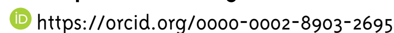
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Abstract

This article aims to understand professional insertion and the identity as sanitarist based on the experience of Collective Health alumni from UFMT-Brazil. The Sociology of Professions, based on Claude Dubar, was used to identify the meanings of professionalization according to the nuances of training and practices in the construction of "being a sanitarist." Using qualitative research, 12 alumni working in Collective Health were interviewed, treated by thematic analysis. One topic focused on the profile, the forms/strategies of professional insertion such as invitations, indications, progression/relocation in the institutions where they already worked, approvals in postgraduate notices and selections with contract. The activities varied in commissioned positions, temporary contracts, statutory, and scholarship holders. Another topic addressed the identity perceptions built in the world of work in the public health network, highlighting the political-social component with a critical role, expressing the commitment of Collective Health to social transformation, improvement of the population's life and health as a citizenship right and duty of State. The professional identity is built procedurally and the insertion in the work occurs through the mobilization of agents, leaving the engagement in the struggle for recognition guided by the Brazilian Sanitary Reform values and a solidary, fair, and democratic society.

Keywords: Collective Health; Professional identity; Professional education.

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Resumo

O objetivo deste artigo foi compreender a inserção profissional e a identidade como sanitarista a partir da experiência de egressos/as da Graduação em Saúde Coletiva da Universidade Federal de Mato Grosso (UFMT). Valemo-nos da Sociologia das Profissões pelas contribuições de Claude Dubar, identificando os sentidos da profissionalização pelas nuances da formação e das práticas na construção do "ser sanitarista". Pela pesquisa qualitativa foram entrevistados/as 12 egressos/as atuantes na Saúde Coletiva com tratamento dos dados pela análise temática. Um tópico enfocou o perfil, as formas/estratégias de inserção profissional (convites, indicações, progressão/realocação nas instituições em que já atuavam, aprovações em pós-graduação, seletivos com contrato). Os vínculos variaram em cargos comissionados, contratos temporários, estatutários (concurso anterior) e como bolsistas. Outro tópico abordou as percepções identitárias construídas no mundo do trabalho na rede pública de saúde, sobressaindo o componente político-social do seu papel crítico, expressando compromisso social próprio da Saúde Coletiva de transformação social, melhoria da vida da população e a saúde como direito de cidadania e dever do Estado. A identidade profissional é construída processualmente e a inserção no trabalho se dá pela mobilização de agentes, cabendo o engajamento na luta por reconhecimento guiada pelos valores Reforma Sanitária Brasileira e de uma sociedade solidária, justa e democrática.

Palavras-chave: Saúde Coletiva; Identidade profissional; Formação profissional.

Introduction

Collective Health is an interdisciplinary field of knowledge and practices in which professionals with degrees in the health area, in other areas, and with specific postgraduate training work. The hallmark of training in this field is understanding health and its social determinants, practices oriented primarily toward health promotion, prevention, and care for diseases and injuries, having as their object not only the individual but also social groups, the community (Bosi; Paim, 2010).

Collective Health is also considered an ideological movement committed to social transformation by articulating scientific paradigms to approach the health-disease-care object, respecting its historicity and integrality (Paim; Almeida-Filho, 2014). In this sense, the significant participation of Collective Health in the movement toward health reform (*Reforma Sanitária Brazileira* - RSB) and the implementation of the Brazilian National Health System (SUS) stands out—facts that drove the reconfiguration of health practices and the labor market in Brazil, with repercussions on professional training in health. Furthermore, in implementing the SUS, the strategy of reorienting the care model (starting in the mid-1990s) with an emphasis on health promotion and comprehensiveness of actions increasingly demanded professionals with a profile in Collective Health. In this scenario, undergraduate training could quickly fill the gap of educational institutions in constituting subjects suitable and sufficient for this new reality (Bosi; Paim, 2009, 2010). This means that "the creation of the undergraduate course, more than a new profession, is about a new strategy for professionalization in health" (Bosi; Paim, 2010, p. 2034, free translation), i.e., it combines the construction of identity (graduate sanitarist) with the stage of development of the field of Collective Health.

Thus, implementing the Undergraduate Courses in Collective Health (CGSC) began in 2008, favored by the Support Program for Restructuring and Expansion Plans of Federal Universities/REUNI (Mendonça & Castro, 2023). Currently, 24 CGSCs are implemented in all regions of Brazil.

Sanitarist as a profession, therefore, is new, having as political and institutional milestones: the inclusion of Collective Health graduates in the Brazilian Classification of Occupations in 2017, which legitimizes the insertion and permanence of bachelors in different workspaces, approval of the National Curricular Guidelines for the Undergraduate Course in Collective Health by the Ministry of Education in 2022, fulfilling a role in strengthening curricula in defining the profile of alumni, favoring guidance and insertion of the area in the labor market and consequent consolidation of the course's identity; regulation of the profession by Law No. 14,725/2023/Brazil, which defines requirements, attributions, competencies, and skills for practicing as a sanitarist.

These milestones are achievements resulting from broad debates and struggles in which the leading role of the *Associação Brasileira de Saúde Coletiva* (ABRASCO – Brazilian Association of Collective Health) stands out, above all, through the Forum for Undergraduate Studies in Collective Health/FGSC, as well as alumni (mainly, through the representation of the Association of Bachelors in Collective Health) (ABRASCO, 2023), among other participating and partner institutions.

In this context, professionalization, seen as a long and complex process of socialization of formal and tacit knowledge that confers specific knowledge and responds to social needs (Bosi, 1996), is relevant in constructing identity and insertion in the labor market. Socialization refers to a relational, gradual, unfinished, and permanent construction of a symbolic code, implying multidirectional dialogue that requires constant renegotiations according to the temporal order, circumstances, and contexts of action, as well as the person's life path, allowing for a representation of the world and the identity assumed in it (Dubar, 1997). Professionalization, then, involves relationships between identity, education/training, work, and career (Dubar, 2012) which implies:

> [...] conquering of one's own space, and it is prudent not to neglect the participation of the student body and future alumni as central actors and protagonists in the creation of a career and the advancement of the professionalization process, as well as the demarcation of their spaces concerning existing professions, based on the profile constructed throughout the course (Bosi; Paim, 2010, p. 2034).

This understanding introduces the subjective dimension, the mark of experience and intersubjectivity, into the analysis (Dubar, 2005), recovering the subject in the professionalization process (Bosi; Paim, 2010). It is, therefore, consistent with the interactionist perspective that contests the functionalist thesis that distinguishes two very different types of work activities: profession and occupation, reserving the quality of the former for a minority of workers organized into "professions," benefiting from legislation that protects their practice and allows their associations to hold the monopoly on their training and certification (Santos, 2005). In turn, the sociology of professions from an interactionist perspective redefines professionalization as a general process (and not restricted to certain activities), postulating that every worker wants to be recognized and protected by a statute and that every "occupation" tends to organize itself and fight to become a "profession" (Santos, 2005). We adhere to this perspective of the Sociology of Professions to approach professional identity by exploring its three intersecting areas highlighted by Dubar (2005, p. 252): the lived world of work, the socio-professional trajectory with employment movements, and the relationship of workers with the training and work they perform or will perform.

Given the above and considering that, since 2010, the Institute of Collective Health of the Federal University of Mato Grosso (ISC-UFMT) has offered the CGSC (evening, 40 places/semester), this text aims to understand professional insertion and identity as a health professional based on the experience of its alumni working in the field of Collective Health. Experience is taken as how concrete subjects experience the world in the existential flow of everyday life, of the set of experiences edited by that marking and touching them, affecting them (Bondía, 2002). The reports of lived experience (related to, but distinct from, the live

experience) present us with striking and significant parts of the experience but not everything that was experienced.

Methodology

This qualitative study values the voice of alumni of the undergraduate course in Collective Health and knowledge through experience with the legitimacy of those who lived/live the process in focus. Thus, in 2019, the ISC/UFMT GSC had 11 completed classes and 93 alumni who were potential interlocutors for this study. Among these alumni, some who worked in the field of Collective Health were identified, and interviews were initiated. Using the snowball technique (Vinuto, 2014), the indication of other people in this condition was requested. The total of 12 participants was delimited by the repetition of names added to the saturation of the themes (Fontanella; Ricas; Turato, 2008), with whom a comprehensive interview was conducted (Kaufmann, 2013), in a private place from May to August 2019, guided by a thematic script focusing on three items: academic and professional trajectory, identity as a sanitarist and daily work. The interview explored and deepened the following aspects: choice and permanence in the course; contribution of the course and subareas to work in the field; self-concept as a sanitarist and interaction with other professionals; general and specific activities performed; professional expectations.

The interviews were conducted by the first author of this article and were recorded, transcribed, and stored on restricted-access equipment. The data were processed using thematic analysis (Gomes, 1994) to identify core meanings. These core meanings were grouped into themes and analyzed based on the successive socializations that occur with people in their educational and work processes in constructing identity (Dubar, 2005, 2012). The results will be presented in two topics, focusing on the profile of training and insertions in the world of work, followed by the experience of "being a sanitarist."

The study was approved by the Ethics Committee (Opinion No. 3,193,556/2018), and the participants were identified in the excerpts of their speeches as *Entrev.* and by random numbering to protect anonymity.

Sanitarists in the world of work: training profile, forms, and insertion strategies

Of the 12 interviewees working in the field of Collective Health, 10 are women, corresponding to the feminized profile in the health area (Wermelinger et al., 2010), with the age range of 30 to 39 and 40 to 49 years predominating (4 respondents each); 3 in the age range of 20 to 29 years; and one over 50 years old. Table 1 below shows the relevant characteristics of the training and institutional affiliation of the participants because it is where they mobilize the knowledge/skills pertinent to the profession.

Table 1. Educational and employment profile of the interviewed alumni

Other undergraduate degree	Postgraduate degree	Institution of employment	Type of employment
Yes 08 No 04	Yes 06[1] No 06	State public 02 Municipal public 05 Federal 05 Private 01	Temporary 04 Statutory 04 Scholarship Holder 05
Total 12	12	13[2]	13[3]

1 — *Lato sensu* completed, with 02 specializations (Labor Management and Health Education, in the area of Biology) and 01 residency (Hospital Management for the SUS); *stricto sensu*/03 master's degrees, 2 completed (Public Health, Collective Health) and 01 in progress (Collective Health)

2 — 01 case of double employment (municipal and private)

3 — 01 case of double employment (temporary and statutory)

Source: prepared by the authors, 2024.

Four had another previous degree (01 Biology, 02 Nursing, 01 Data Processing Technology), suggesting familiarity with the academic world. Possible job insertion and training complementation in Collective Health can allow the assumption of functions that value and demand this requirement in public health institutions, therefore meeting the proposal to reorient the dominant care model (Bosi; Paim, 2010).

Similarly, six interviewees had postgraduate degrees, which presupposes the need to deepen specific knowledge/Collective Health but also allows for career progression; an alternative or strategy for remaining in the field, increasing employability or, as Silva, Domingues, Rocha (2017) said, circumventing the reality of limited opportunities for insertion in the labor market. This exposes what has already been found about the insecurity and fragility of the type of employment relationship and the adequacy of remuneration, which may lead to the incorporation of these professionals with precarious work relationships (Lorena et al., 2016; Silva, Pinto, Teixeira, 2018).

Nevertheless, postgraduate training (especially specialization and residency) allows quick and localized responses to institutional/service technical demands, sometimes filling gaps or insufficiency in the undergraduate degree. Let us look at the search for postgraduate degrees.

> *It was because, as I also think about teaching, the degree is essential; whether I like it or not, where can I find a Public/Collective Health course!? In Federal Universities, for me to be able to get a job as a professor, I wouldn't be able to do it just as a sanitarist. So, it was a... a thought as a continuous sanitarist* (Entrev. 3).

> *What led me to take the Residency was the opportunity I saw to continue at Collective Health and, through the Residency, improve my knowledge in management, which is the focus of the CGSC at UFMT since the Residency is in Hospital Management. So, I saw this opportunity to continue in the area of Collective Health since I identified with Collective Health* (Entrev. 11).

> *I wanted to get into teaching, I really did. (...) I have always wanted to, like, this part of teaching, of interaction, of passing on knowledge. I always liked it. In fact, when I worked [in the state of XX], I always liked giving courses and training. I've always liked it a lot! So, one of the motivations for enrolling in the master's degree was that. It was the teaching aspect* (Entrev. 12).

Regarding institutional affiliation, five are scholarship holders (postgraduate studies); four have tenure in public/statutory services, three of whom passed civil service examinations before graduating in Collective Health; three are hired higher education professionals, and one of them has a higher education teaching position in a private institution. At the time of the study, the possibilities in civil service examinations for these participants for the position of Higher Education Professional of the SUS (with and without specialization) were given by the profile of the first degree or by the requirement of specialization in Public Health, given that only in 2022 was there the first notice from the municipal health department in the capital/Mato Grosso with vacancies for graduated sanitarists. The alumni interviewed work in units linked to the SUS, with the public sector predominating as the large employer, i.e., they are salaried. As Diniz (2001) reminds us, few professions were born autonomous but rather salaried within organizations, subject to controls, rules, and routines.

The predominant activities performed are health management in positions/functions in the public sector, the residency's theoretical and practical activities, research in Collective Health (master's degree), and one case of teaching.

In general, in the personal trajectory, after the undergraduate education, the specific moment of professional life follows: from student to employee, but also unemployed, looking for a job, employed, continuing the postgraduate education in service or not. Considering that identity is "the result at once stable and provisional, individual and collective, subjective and objective, biographical and structural, of the various processes of socialization" (Dubar, 2005, p. 136, free translation), it is necessary to consider that such construction occurs in the world of everyday life, inscribed in the experience, in the professional case, through insertion in the world of

work. This insertion promotes the contours in the constitution of the professional identity when the alumni become members of a professional segment, internalizing and mobilizing knowledge and specific practices of the profession as an experience of appropriation, forging the identity for themselves *in loco*, directly learning from work and in personal/professional and institutional interactions (Dubar, 1997, 2005).

Regarding the professional insertion paths of the interlocutors, they occurred through invitations, recommendations, and previous work in the sector in which they worked and approval in selection processes/civil service examinations (due to prior training), as in the findings of Silva, Pinto, Teixeira (2018). It is, therefore, a field of possibilities, that is, a list of alternatives presented to individuals based on broader socio-historical processes throughout each trajectory (Velho, 2003), in this case, providing the opportunity to work as a sanitarist. In other words, they are opportunities for choices, in alternatives demarcated historically and conjuncturally.

In this sense, good performance in curricular internships can be one of these opportunities to demonstrate the skills and abilities acquired through training (Bezerra et al., 2013a; Lorena et al., 2016), highlighting the need for that professional profile that can make a difference, in the management of the health system. Internships can reflect academic training and a projection of oneself for future professional performance in the constitution of identity (Dubar, 2005). In this space of theoretical-practical articulation, students glimpse the gaps and potentialities of the pedagogical process, making them think about the profession and the consequences of daily health actions (Pereira & Carneiro, 2019), forging credibility for a promising performance in the institution.

Many skills and competencies are developed during the internship, such as recognition, explanations, proposals for problem-solving, participation in decision-making processes, and proactive attitudes (Viana; Souza, 2018). It is through practice that the skills of a given profession are integrated (Bezerra et al., 2013a; Silva; Ventura; Ferreira, 2013). The specific knowledge and languages of the profession and the dialogue with action allow the capacity for action, directly confronting problems. In other words, the methodology of learning by doing and thinking allows the individual to build personal ways of knowing and acting, making a difference in their insertion into the labor market (Caires; Almeida, 2000).

We, therefore, believe that technical and political indications for positions of trust or invitations to be hired civil servants do not disqualify the graduated sanitarist. This is because the indications are mediated by the fact that these alumni, in most cases, have demonstrated their potential to employers during their activities with the health system, in practical scenarios (such as internships), being a path in the employment movement (Bezerra et al., 2013a; Viana; Souza, 2018) in the professionalization process.

The multiplicity of academic experiences of students (during their training) enhances the possibilities of expanding and fulfilling their role in society, providing the opportunity to put their knowledge, thoughts, and actions into practice, making visible the specificity of the work of sanitarist forging bridges and doors of access to the market. Thus, when there is a confrontation with the labor market (and the skills are recognized), status is given to the candidate, and career possibilities (becoming more precise)—reinforce and confirm a professional identity (Dubar, 2012). This conquest of space is notable in the following words.

> *Whether you like it or not, it is when you show your potential in the internship, your work. So, I always tried to show what I knew and what I could do because I knew it from the beginning; I always knew that the area of Collective Health is not valued yet in terms of civil service examinations, contracts, and these things. So, for me to get a job, for example, where I am, I had to show that I knew how to do it; I had to be good at what I do* [...] *Because whether you like it or not, it has to be a way for you to show what you do and then you see the result. I think the result is being seen in the service, showing your potential in the service, and getting you a space* (Entrev. 1).

> *It was through the internship I was doing in my last semester*[*8th semester*]*. I was doing some work at the reception desk regarding the quality*

of user care. From this result, the work we did here was presented in a kind of lecture there at XX [*cited public health unit*]. *I presented the results showing the importance of improving care and expanding the way of providing it, specifically to help the user find their way in the search for their health. The Superintendent of XX was there, as were some colleagues from XX* [*another health unit*]. *At the end of the presentation, the Superintendent invited me to work. It was that simple. He invited me to work. He said he liked what he had seen. I have been here for a year and five months now* (Entrev. 10).

In the excerpt below, we can see that invitations to management positions in public health services are proliferating, expressing prestige and responsibility for caring for the population on a collective level concerning health services and the SUS. Such repercussions build, reinforce, and strengthen recognition by making visible and propagating the image, role, and potential of the graduated sanitarist (Bezerra et al., 2013b) as a showcase for more than just the individual case, who can achieve and leverage the category towards professionalization. It also configures what Velho (2003) calls *metamorphosis* for the possibilities in which the person flexes projects in their trajectory, always open and in constant changes and transformations in time and context of insertion. Let us see:

[*inserted*] *At the invitation of the manager himself, who at the time received the call to take over the State Department of Health. Then, a month later, I was invited to a new experience, a new challenge: to be a manager* [*of the public health sector*]. *I received an invitation from the manager himself when I announced my departure from the office at the end of a CIR* [*Regional Intermanagerial Commission*], *which was a meeting that I led, agreed on deadlines, addressed some critical issues, and, at the end of the meeting, I said goodbye because I had already filed my resignation request. After that, I received several invitations from some municipalities to talk, and the one from XX* [*cites municipality*] *proposed to me: 'Look, I want you there to help me because there are a lot of things in the municipality that we need to address, I need someone like you'* (Entrev. 2).

As can be seen, some interviewees already worked in the SUS as Higher Education Professionals in a specific profile from their first degree. However, with the interdisciplinary training provided by Collective Health, they could improve the work they developed, broadening their vision of health, as illustrated in the third and fourth excerpts below.

I wouldn't have the vision I have today. I believe I could seek to improve [*if I hadn't graduated in CH*], *but I wouldn't have the vision and wouldn't use the instruments I use today, for example. I use statistics a lot. The sector I was in was a hospital statistics service. And I believe that without this vision from the degree, I wouldn't be able to do the calculations and analyses. Because it's not just the calculation; you have to do the entire analysis of that calculation. Because an indicator is just a number. You need to work on that indicator because the manager doesn't understand what 50% is or 40% is; you have to do the analysis and write a little text below saying what that means* [...] *The training in Collective Health provided me with that. Definitely! Because one of the pillars of Collective Health is Epidemiology, which includes statistics. So I've always gone back to that area; I've always been very much into that area* (Entrev. 5).

The degree in Collective Health helped me a lot. Yes, a lot, indeed! A lot! Because in the case of UFMT, they work it [*the CGSC*] *more concerning the management, the assessment, and this is a serious problem that we have in the* [*Health*] *Department. It's a huge problem just to sit down and assess because a lot is happening. There are 141 municipalities that we need to monitor; we need to be aware of 141 particularities to analyze and propose intervention actions. So, this course helped us better connect all the people in these municipalities [health professionals] to suggest specific and broad actions for each Health Region* (Entrev. 9).

I consider myself more of a sanitarist [*laughs*]. *I always introduce myself as both* [*professions*]. *I'm x* [*profession of the first training*], *and I'm a sanitarist because I have training in both, so there's no way* [*to separate them*]. *I say that all my insertion was given to me by x* [*profession of*

> *the first training*]. [...] *My civil service examination is for x* [*profession of the first training*], *but the qualification of my performance was given to me by Collective Health* (Entrev. 7).

> *I have the perspective of Y* [*profession of the first training*]. *I know the names of the procedures; I know everything, technically speaking. And I know how to analyze what is done. For example, the demand for health, what is the greatest demand for health? Which sectors demand the most? What are the procedures? All of this requires knowledge of a nurse and a sanitarist, for example. How am I going to analyze where the health need is within that hospital? Because of my training in Collective Health. If I didn't have a degree in Collective Health, I wouldn't have the vision I have today* (Entrev. 5).

Therefore, the alumni consider themselves to be inserted in the world of work in Collective Health and the SUS, acting as sanitarists. It is now pertinent to understand what it means to "*Be a Sanitarist"* based on the knowledge of experience, the mark of what has been lived, intersubjectivity, and their place of speech. This is because such ideas and practices as sanitarists tell us about the identity that, in the daily work routine, feeds back into the professionalization process, as Bosi and Paim (2010) said, which is the following subject.

"Being a Sanitarist": experience and identity construction

The selected data came mainly from the question in the thematic script: "*Do you consider yourself a sanitarist? Why? Tell me about it."* For the analysis, we used basic concepts that Dubar (2005) proposed: identity for oneself, acts of belonging, and professional biographical process.

For Dubar (2005), "professional self-conception" develops after graduation, when the individual internalizes a new professional image that becomes a significant aspect of their personality until entering the labor market, constituting the professional biographical process. However, in this case, some of our interlocutors were already in the world of work with another degree profile so that the degree would improve, aggregate, and legitimize specific skills and competencies in a *continuum* that is more than a rupture. This means that these professionals will continue with the duties of their professional profile, with a bonus provided by the new degree, in the manner of postgraduate education, especially the *lato sensu*. The diploma allows access to an esoteric body of knowledge (Wilensky, 1970) in the field of Collective Health that is concentrated in the new undergraduate course and that was sparse, diluted in subjects, fragmented, and localized in the classic courses in the health area and, even, as Bosi and Paim (2010) said, in postgraduate training.

The first excerpt below tells us about the self-conception linking "being a sanitarist" to acting (an idea shared by another alumni), i.e., it shows the strength of concrete practice in the field of Collective Health, applying what was learned in the undergraduate course and following the respective values and principles. It refers to what Dubar (2012) calls initiation and identity conversion, when the individual begins to mobilize knowledge in practice, articulating it with theory through insertion in the world of work. While the distinction mentioned above seems to reside in the inseparability of knowing and doing, it makes us wonder whether the "acting," "work," and experience of Collective Health mentioned would not be closer to the meaning of activism that is striking in the field and in the training that, in part, was given before the creation of the degree in question. Distinct from contestation (specific actions) and engagement (continuous actions in time and space), activism embraces and transcends both because more than a continuous disposition, it implies sociopolitical 'dedication,' comprises 'personal involvement,' a trajectory of action and, above all, socialization (Steyer & Cadoná, 2018, p. 460). In other words, a whole range of experiences, positions, knowledge, practices, interactions, communications, and activities developed in a given environment, allowing individuals to become subjects (develop needs, capabilities, competence to act, personal qualities, worldviews of a given cause), these latter authors state. Collective Health and the SUS constitute a cause committed to rights and social justice. Let us see.

I see the difference between being a Sanitarist and having a Bachelor's degree in Collective Health. Based on my experience, I see myself as a Sanitarist, yes! But I think most people have a Bachelor's degree in Collective Health, indeed. Many of us have never even worked in the field. Perhaps others will never work in the field. And I think those who do not experience Collective Health cannot understand it. For me, Sanitarist is more about acting, about a position, about being in..., really in healthcare, let's say, whether it's management or accounts. I think there are Sanitarists in all areas. Now, to say that everyone who graduates [*in Collective Health*] *is a sanitarist: I wouldn't say that! That's a Bachelor's Degree in Collective Health. The Sanitarist is the one who acts, the one who goes to work* (Entrev. 3).

For me, being a sanitarist means actively participating in the management, planning, and organization of the healthcare network, of the SUS. In general, at the primary, secondary, and tertiary levels, and in surveillance. It's this practical action, creating this link, managing, planning, and integrating. There's no way to sum it up like this: for me, the sanitarist is very focused on the management, i.e., the management of the healthcare system (Entrev. 7).

The following statement about *Being a Sanitarist* gives us clues that identity is not constructed as if by magic from one moment to the next (just by being trained) but instead in a process where the recognition, appreciation, and confirmation of personal and professional experiences evidence and support the construction of identity itself. Recognition is formed in professional action and communication. These are detailed by the contexts of intervention, by the actors, and by the objects of professional practice so that a significant part of professional identity is generated by experience, i.e., in the concrete exercise of professional training in constant interaction with other professionals and manufactured in the diversity of agreements and disagreements between the virtual identity (proposed or imposed by others) and the real identity, assimilated by the individual (Santos, 2005, p. 132; Dubar, 2012).

Ah! Today, yes! Today, yes, after all this experience, but at first, we felt a little lost, you know, about what I'm going to do and how I will do it. I even had difficulty finding myself. In fact, will I be able to do this? Will I continue? I won't reveal much, but today, yes, I see that I have succeeded. I am managing to develop myself as a sanitarist. After all, it is something that never ends. I graduated, and I know. You leave college with a certain amount of experience, but a professional is built over the years and through the experiences that they go through. So, they acquire some knowledge, and then, yes, they can have more clarity about what their role is and what their actual role is. Unlike a course more focused on biology, you know, you graduate knowing that you are a nutritionist, you will follow a diet, you will work with this. You leave nursing school knowing how to bandage and do this and do that. We [*sanitarists*] *don't. There is no recipe for becoming a sanitarist, although you do have some guidelines, but you are made up of the experiences you will go through* (Entrev. 2).

The interdisciplinary field of Collective Health has, as one of its commitments, the defense and implementation of the Brazilian National Health System (SUS), valuing the need to train qualified professionals to transform practices and to mobilize politically to change care models. As seen below, "being a sanitarist" means, based on gathering knowledge from its constituent areas, extending and broadening the view of health beyond the individual, and understanding the complexity of influences not explained by the biological without excluding the individual. This broad view is based on considering the social inequalities engendered by social, environmental, economic, cultural, ethnic, racial, psychological, and behavioral processes that influence (exposing or protecting) the occurrence, amplification, protection, or mitigation of health problems and injuries and risks to the population (Buss; Pellegrini-Filho, 2007); understanding and defending the equality of the right to health and confronting inequities; promoting health and well-being. However, the speech embodies the multiprofessional rancor, prone to fragmentation and juxtaposition of specialized knowledge.

It may be more productive to extrapolate to an interprofessional perspective linked to the notion of health teamwork, marked by reflection on professional roles, problem-solving, and negotiation in decision-making processes, based on the construction of knowledge in a dialogical way and with respect for the singularities and differences of the various cores of knowledge and professional practices (Alvarenga et al., 2013).

> *It's a wonderful thing [being a sanitarist], which gives you a comprehensive vision that makes you build some contexts that others can't. The good side is that you can do some analyses, but the poor side is that not everyone follows your analyses. They don't follow [other professionals]. So, in the service, when you're explaining why something must be done, the person can't understand that there's a policy behind it. The person thinks you're doing it because you want to. I'm not doing it because I invented it today. There's a whole policy, a set of regulations, and not everyone understands that! That's complicated* (Entrev. 5).

We agree with Dubar (2005), who believes that identity for oneself is inseparable from identity for the Other and is so in a problematic way; i.e., it is always correlated with the Other and its recognition, but the experience of the Other is never lived directly by the Self. This is because interactions take place in the same shared world and in an intersubjective relational logic in which the constitution of the world, of the things that exist in it (including Self/Other), and of the consciousness that one has of it, occurs "between subjects," in the collective so that each one can be subject and object in reciprocity (Marsciani, 2014, author's emphasis). Therefore, to affirm what one is a professional (in this case, a Sanitarist), it is also necessary to be informed about what the other people attributes to us to forge an identity.

> *Every opportunity we have [to enter the job market], we demystify, trying to position ourselves as a Sanitarist. The Secretary [of Health] already understands this, but it is more complex for the team. Some already know that due to their specializations, they have specializations in Collective Health and Public Health. However, we must constantly reaffirm ourselves for the specific training [undergraduate degree in Collective Health*] (Entrev. 2).

> *The difficulty is to make them understand what we* [*sanitarists*] *are for, what our work is, what the difference is between our work and theirs [other professionals], and for them to see us as Sanitarists. This is a difficulty* (Entrev. 7).

Ultimately, professional identity is a process, and as such, it is unfinished, relational, always being constructed/deconstructed/reconstructed in a non-linear way through interactions (articulated micro and macrosocial, objective and subjective) and learning, which gains concreteness (material and symbolic) in the articulation of training, projections, experience in the world of work in political and institutional contexts, which legitimize belonging to a given category.

Final considerations

The results revealed diversification in the movements and forms of insertion and action in the world of work based on professional paths and identity dynamics in a field of possibilities. Understanding such trajectories becomes a challenge and an opportunity for the training institution, alumni, students, and professors, as well as for the health system and managers. In the movement to recognize the category for action, it is important to consider that professional identity is built in close relation to public health policy in the different governmental spheres that encompass the construction of the SUS, even though there is a perceived mismatch between the need for the new profile and the institutionalized opportunities for insertion.

It was possible to perceive that the alumni interviewed see themselves as strategic subjects, having the necessary tools for an expanded vision of health, recognizing that the training in Collective Health has enabled them to develop the health work process in their places of work. Those who had a degree prior to Collective Health, already working/linked to the public health system, legitimize that

specific training in Collective Health is empowering and provides more efficient responses at work than, strictly speaking, the contribution of the first training that accredited insertion in the public health network. However, if we see the relevance of practice in training in Collective Health, we must consider that some of the alumni already had practice from insertion in the labor market, knowing and moving through the health system, which may have favored the use of the new degree.

The challenges of employability in the professionalization process, as in other professions, reveal the importance of the debate on the need for graduated sanitarist beyond discussions on identity and professional insertion, but increasingly on the joint alignment between the training process and the professional development of this category to carry out work in Collective Health aligned with the SUS as a citizenship right.

As a study limitation, the identity issue was not analyzed with all the alumni (although they were carefully selected and delimited by qualitative research technique), nor the inclusion of alumni (monitoring of alumni). It would be pertinent to look at the repercussions of regulating the profession for future studies. Furthermore, we cannot neglect the current context of the curricularization of extension, which may constitute a promising opportunity for the practices of sanitarists with reflections on the construction of professional identity.

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