COLLECTIVE HEALTH: CONTRIBUTIONS TO BRAZILIAN POSTGRADUATE EDUCATION

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"*The field of Collective Health is one of the most fertile and advanced fields in the tree of academic knowledge"* LUZ (2009, p.310).

Introduction

One of the most common statements pertaining to Brazilian postgraduate education is that it is a successful project, despite facing problems and challenges. The statement made by BALBACHEVSKY (2005, p. 275) fifteen years ago, that "the successes achieved by the country in postgraduate education have been a source of pride for both the Brazilian academia and public authorities", relates to what had already been stated by Darcy RIBEIRO (1980 p. 73), quoted by ALMEIDA (2017, p. 16): "The Brazilian postgraduate experience in recent years is the most positive thing in the history of higher education in Brazil, and is also the one that needs to be taken seriously." The phrase, which has been the epigraph of articles and theses, was commented on by Santos (2003, p. 628), according to whom RIBEIRO's assessment (1980) needed to be analyzed under several facets and possibilities: "scientific and technological development", "continuity of academic career", "vocational training (for professors or otherwise)" and "dependence on external models [...] in its implementation", for the country to set its postgraduate system "back on the right path" when needed. More recently, ALMEIDA (2017, p. 16) emphasizes his "authority [not only] as an intellectual", but [...] as someone who has "experienced the university before and after the implementation of postgraduate education", which allowed him to develop a "critical perspective" of Brazilian higher education in the 1960s, referring to postgraduate school as its "point of inflection".

These initial observations refer to the 1960s, when the process of establishment of postgraduate studies in general began, those in collective health having emerged from 1970 onwards, in the context of the long Brazilian dictatorial regime (1964-1985).

The history of postgraduate education will be briefly analyzed to contextualize the institutionalization of collective health and its unique contribution to the field of the Health Sciences and the Social and Human Sciences, and to postgraduate studies as a whole, based on the published literature on postgraduate education and on the field of collective health and related areas. The article begins with the historical aspects of postgraduate studies to then address the concept of collective health and its historical-institutional-pedagogical trajectory, concluding with its contributions.

1. Brief History of Brazilian Postgraduate Education

1.1. General Aspects

Undoubtedly, the character who would become a central figure in the officialization of Brazilian postgraduate studies is Newton Lins Buarque Sucupira (1920-2007), a professor, philosopher and lawyer, after whom Report 977/65 would be named – the Sucupira Report, as told in a long 1980 article on the background of postgraduate studies. He emphasizes that “Obtaining a doctorate through the simple defense of a thesis has always existed in Brazilian higher education,” considering that doctoral courses appeared, for the first time, with the Francisco Campos Reform, in 1931. The Brazilian Universities Statute (Decree No. 19.851, of April 11, 1931) provided for a European-type doctorate, with a thesis defense, “after other regulatory requirements of the respective institutes had been met” (SUCUPIRA, 1980, p. 3). Sucupira clarifies that Francisco Campos did not use the terms “undergraduate” and “graduate”, distinguishing bachelor’s degree programs “of a purely professional order”, aimed at “the training of legal practitioners”, from doctoral programs, specifically aimed at “the training of future law professors”. The course had a two-year duration. In relation to the historiography of the trajectory of postgraduate studies, he mentions the fact that “the first legal document to use the term “postgraduate” to designate a higher education modality” was Decree No. 21,231, of June 18, 1946, which instituted the Brazilian Higher Education Statute (SUCUPIRA, 1980, p. 6).

The first master's and doctoral courses were established at the beginning of the 1960s, namely: Escola Superior de Agricultura de Viçosa; Federal University of Rio de Janeiro (University of Brazil at the time); Aeronautics Technology Institute (ITA); master's and doctoral programs in Chemical Engineering at the University of Brazil. SANTOS; AZEVEDO (2009, p.535) point out that in the 1960s, Brazil had 38 courses, 11 of which were doctoral and 27 master's programs. However, there was no clear definition of the aims and objectives of postgraduate education, nor of its structure.

ALMEIDA (2017, p. 27) raises the "hypothesis that postgraduate studies in Brazil were structured as an Invented Tradition [according to the concept of Hobsbawm, 2012] within the Brazilian university," being different from the experiences of 1931 and thus "unable to have their origins associated with that moment [Decree of 1931]."

The author details how Report No. 977/65 was seen in the most different ways: "it founds", "it formally implements", "it inaugurates", "it institutionalizes", "it regulates", "it formalizes", "it defines", "it standardizes" , "it conceptualizes" [...], among others. About the Report's importance, she states:

> there is a before and after Report No. 977 of Sucupira, not only from the point of view of the concepts it defines, but mainly, for instituting new practices referring to the staff qualification, researcher training, and knowledge production processes (ALMEIDA, 2017, p. 27).

As stated above, the political context in which the Report was created cannot be minimized, i.e., the presence of the civil-military dictatorship that lasted 21 years and was consolidated with Institutional Act No. 5 (12/13/1968), which suspended individual guarantees and the writ of habeas corpus, and established imprisonment for an indefinite period.

There are different perceptions about this issue. For Cunha (1991, p.59), cited by SANTOS; AZEVEDO (2009, p. 536), what takes place is a "technicality supported by a type of regulation that is specific to a state of exception" and based on the North American model, but he also considers that "the great momentum achieved by this level of the education system after the 1964 coup cannot be denied." Additionally, according to the author,

> During the military regime, despite the repression that mutilated libraries and programs and expelled professors and students from the education system, no public university was closed down and there were more resources for their expansion, allowing the development of activities deemed as essential to their existence: cultural production and scientific and technological research (although within the limits of repression and authoritarianism and aimed at the education of ruling elites.)

BOMENY (2001, p. 108) does not share this position. For the social scientist,

> A closer view of Newton Sucupira's ideas, opinions, conceptions and intellectual orientations left me convinced that his beliefs were not conditioned or inspired by the authoritarian regime.

Diametrically in opposition, TAMBELLINI; BOTAZZO; NUNES; BUSS (2015, p.69) manifest themselves as follows: "To talk about the lead years in Brazil is to go back to the military dictatorship that, for 21 years (1964-1985), exposed its most cruel and perverse face, that of the repression of the State under the regime of terror."

1.2. Quantitative Evolution of Graduate Education

According to NAZARENO; HERBETTA, (2019, p. 104, 105), I PNPG (1st National Postgraduate Plan) was instituted during the government of Ernesto Geisel (1907-1996), in the Ministry of Education and Culture, whereas "the creation of the Council and PNPG, on the other hand, originated from a request from MEC itself, which decided to create a national postgraduate policy in 1973." At that time, there were "50 higher education institutions in which postgraduate courses were held: 25 federal, 10 state and municipal, and 15 private." On that date, "7,000 vacant spots were filled up, with a total of 13,500 students enrolled in different phases," and the system awarded "approximately 3,500 master's and 500 doctoral degrees, of which about 50% were absorbed by the teaching profession and the rest by the professional labor market." The authors highlight the presence of

> isolation and disarticulation of initiatives; insufficient support and guidance on the part of the governing bodies of education policies; and on most cases, a great diversity of sources and forms of financing.

Postgraduate education evolved rapidly. Taking a big leap in time, the 2017 data show its growth. In the 2013-2017 Quadrennial, 4,175 programs and

their 6,303 courses were evaluated, consisting of 3,398 master's programs, 2,202 doctoral programs, and 703 professional master's programs. During this quadrennium, there was a 77% increase in the number of professional master's programs. The number of academic master's and doctoral programs also evolved, increasing by 17% and 23%, respectively. (CAPES, 2017, n.p.)

2. Collective Health: Concept and Trajectory

2.1. The approaches

There are many approaches used to understand the origins and development of Collective Health; an exhaustive bibliographic citation will not be made, but the reader is suggested to see the recent study by VIEIRA-DA-SILVA (2018, p. 29-31), who stresses that her analysis of the origins "arose from the adoption of the sociology of Bourdieu", for whom "historical analysis is necessary for the interpretation of the social world". In a previous study I highlight the main expressions that have been used in an attempt to characterize Collective Health (NUNES, 2020).

Some scholars emphasize that Collective Health is a "Brazilian invention," which leads to serious problems in its translation, in the literal sense and in relation to its significance in the international context, especially in English, language in which it is commonly referred to as *Public Health*, requiring clarifications regarding its meaning. SCHRAIBER (2018, p. 18-20) deepens the issue of "invention" based on the analysis made by Vieira-da-Silva (2018), highlighting the richness of the "testimonies of the founders" when they become "contemporary but diverse actors, and authors of a common historical project, in which, therefore, they register different processes". For Schraiber (p.18), "the social genesis of Collective Health was an invention, the time of its social birth being the context of the possible histories for the creation of new societies." I will return to this topic at a later time.

2.2. Institutionalization

The theme of institutionalization has already been addressed in a previous study (NUNES, 2016), but its presence in this article is essential since it

centralizes the understanding of the process of postgraduate education in collective health.

It is important to note that the institutionalization of Collective Health has completed all its phases, adopting the notions developed by COLLYER (2012, p. 52, 53): the *connectivity and communication* phase, encompassing the first informal meetings of working groups and professors and the exchange of experiences, focusing on problems instead of theoretical themes; the *regularization* phase, encompassing the regularization of discourses, practices and forms of organization and attraction of new members; the *incorporation* phase, encompassing the search for a physical location, as well as financial and material support; and, finally, the *legitimation* phase, which is consolidated by building its culture within the scientific community (accreditation, social communication networks, scientific associations, creation of specialized publications, material and financial support) (emphasis added.)

In addition to the completion of all phases of institutionalization, this proposal allows us to analyze the three moments of the trajectory of Collective Health: the preventive care project (1955-1970), social medicine (1971-1979), and collective health (1980-). The main characteristics of these moments are briefly presented below (NUNES, 2016).

The preventive care project derived from meetings held by the Pan American Health Organization (PAHO) in 1955/56, which emphasized pedagogical practices without a theoretical basis, ideologically conceived in the United States. The main question raised in this formulation aimed to reorient medical practice by developing comprehensive, preventive, community and social attitudes in medical students, thus restructuring medical knowledge. In the absence of a theory to support these practices, the model of the natural history of the disease was adopted, created in 1965 by Hugh R. Leavell and Edwin G. Clark, and translated into Portuguese by Donnangelo; Goldbaum; Ramos (1976). This was a period of intense participation of professors in the preventive and social medicine departments of Brazilian medical schools, the first of which were created at that time: FM/USP/Ribeirão Preto (1954); UFMG (1958); FCM/Santa Casa de São Paulo; FCM/UNICAMP/Campinas (1965);

FCM/UNESP/Botucatu (1965); FM/USP (1967); UFRJ, UFBA (1970). In this context, academic practices based on prevention and health education stand out, including the first experiences of *extramural activities* (work in peripheral neighborhoods and urban communities). The natural history model and the practices adopted were criticized and, in the second half of the 1970s, the ruptures that could already be felt at the beginning of the decade worsened (Nunes, 2016, p. 350).

AROUCA (1975, p. 124) states that

> In the original model of Leavell and Clark, the social factor is also the ' causal factor, connected to the host and the environment, working in both as a set of characters connected to the individual, such as economic and social status, attitudes in relation to sex, etc., and to social institutions and structures that are very characteristic of certain groupings, such as family, community, etc.

This comment led Arouca (1975) to point out that changes "involving the [whole] paradigm considering the Social, Economic and Cultural Context" needed to be introduced. This observation was complemented by the fact that

> in reality, the social factor appears only in name and not as an explanation mechanism, being simply referred to, either as a feature of individuals or enveloping the model (p. 124).

The second moment, called social medicine, begins with the critique of preventive care and community medicine, including the issue of Latin American health planning, and is accentuated in 1976, with the creation of CEBES (Brazilian Center for Health Studies), but also with the repercussions of the Conference on Primary Health Care – (Declaration of Alma-Ata), held in 1978, for the field of health. As quoted by Nunes (2016, p. 352):

> In a scenario that is strongly permeated with the search for innovations and alternatives, by breaking with conventional models of preventive and social medicine, we are moving towards a "new" project, social medicine, rooted in the European social medicine movements of 1848.

Discussions to implement this project took place in the preventive and social medicine departments, from 1968 to 1973, but also in the Meetings of the Pan American Health Organization, which issued a document on the subject in 1974, pointing out that *health is the issue*: "Understanding this objective as its

central concern, social medicine is about studying society and analyzing the current ways of interpreting health problems and medical practice" (quoted by Nunes, 2016, p.352).

The idea of this article is to work not with a linear history, but with periods in time, pointing to ruptures, overlaps and new concepts. Thus, the third moment – that of collective health – officially builds its identity in the late 1970s and early 1980s, by systematizing knowledge (epistemic formulation) and practices (external structures and organizations – educational and governmental). The Preliminary Document of the creation of ABRASCO (Brazilian Association of PostGraduate Studies in Collective Health), written in 1979, points out that [postgraduate] education should be guided by

> a process that generates a critical analysis of the health sector in the social reality in which it is inserted, being potentially able to influence the field of teaching, research and service provision (ABRASCO, 1982, p. 114).

As for the 'programmatic content,' it proposes:

> establishing an appropriate balance between technical and theoretical-conceptual content, between the "biological" and the "social," between the "operational" and the "critical," as a way to avoid the "technicalities" and "biologism" present in the teaching tradition of the field of Collective Health (ABRASCO, 1982, p.114).

3. Formalization of the Field of Collective Health and PostGraduate Courses in the Area

3.1. Stages of formalization and denomination

The idea of formally organizing a field and an entity called "Collective Health" was discussed in four stages:

1. **1978** – 1st National Meeting on Postgraduate Education in Collective Health – Salvador (BA). VIEIRA-DA-SILVA (2018, p. 118, 119) reports on this meeting in detail, without mentioning the precise date: "organized as part of the strategy for the reformulation of the Master's Program in Community Health (MSC) of UFBA, created in 1973, with funding from the Rockefeller Foundation, it corresponded to 50% of the Program's operational costs." In her text, she analyzes the course's trajectory and the changes that took place, including

seminars with the presence of researchers who were part of the “vanguard of Social Medicine,” like Donnangelo, Luz, Nogueira and Guimarães, and foreigners like Laurell, Foucault and García. According to VIEIRA-DA-SILVA (2018, p. 119), “When discussing the name of the meeting, the terms ‘Preventive Medicine’ and ‘Public Health’ were excluded due to the theoretical criticisms made in the theses of Arouca and Donnangelo,” and the name ‘Social Medicine’ was also “vetoed by the collegiate,” which proposed the term ‘Collective Health,’ understood “as a substantive expression, on which a consensus was reached at that meeting.” The author notes that the expression had already been used in the University Reform of 1968, in the textbook of the Experimental Course at USP, held in 1971, and in an article by Guilherme Rodrigues da Silva, of 1973. However, the discussion was not over. It was brought up by Carlyle Guerra de Macedo in the coordination of the meeting of the Program for the Strategic Training of Health Personnel (PPREPS), in Brasília, in 1979, when the creation of an Association was proposed. VIEIRA-DA-SILVA (2018, p. 120) reports that the idea surprised most of the participants, and again the question of the denomination surfaced when Guerra de Macedo asks “what would this association be called”. According to him, it could not have been ‘*Hygiene*’ (the Brazilian Hygiene Society already existed), and ‘Public Health’ “had a very limited connotation.”

2. 1978 (18-20/December) – Meeting in Ribeirão Preto (SP) sponsored by the Pan American Health Organization (PAHO) and the Latin American Association of Public Health Schools (ALAESP). The possibility of creating the Brazilian Association of Postgraduate Studies in Collective Health (Abrasco) emerges, bringing together all graduate courses in this area.

3. 1978 – Due to its importance in the institutionalization of Collective Health, the participation of the financing programs of FINEP (Financier of Studies and Projects) is included, the most comprehensive study on which is that by RIBEIRO (1991). FINEP was established on July 24, 1967, and on March 15, 1985, it becomes associated with the Ministry of Science and Technology, created on that date. The Ministry was extinguished on May 12, 2016, and its structure became part of the Ministry of Science, Technology,

Innovations and Communications (MCTIC). According to RIBEIRO (1991, p. 27), “the first programs for investigation and training of human resources **specially** organized for the structuring of this new field [Collective Health] in Brazil were developed in the second half of the 1970s, more specifically in 1975-1978” (emphasis added). This statement is corroborated by FLEURY (1985) and COSTA; RIBEIRO (1990). There were three programs for the “social area of the institution”: Program of Socioeconomic Studies in Health (PESES), Program of Population and Epidemiological Studies and Research (PEPPE) and Program of Support for the Master’s Course in Social Medicine of the Institute of Social Medicine of the State University of Rio de Janeiro (IMS/UERJ). The author synthesizes this process by stating: “Collective health was established as a new scientific field in Brazil through the movement by which it becomes the object of a specific scientific policy and its production starts being regulated by the state apparatus” (RIBEIRO, 1991, p. 28).

According to COSTA (1992, p.130), “The program of support for collective health was instituted at FINEP in 1978, assuming the territoriality that was part of the intellectual culture of that context [...]”. The author transcribes long excerpts from the FINEP document, in which he points out the biases in the analysis of the health and disease process – “the acceptance that infectious and parasitic diseases would be the country's main health problems (at a time when chronic-degenerative diseases and external causes already weighed significantly)”; ‘the concentration of the reformist will on the level of environmental changes,” and “the disqualification of curative care as an object and the resurfacing of the preventive ideology”. He adds that it would be wrong to consider that these initial theoretical biases “narrowed the development of research between 1975 and 1978” (COSTA, 1992, p.131). COSTA (1992, p.134) presents the distribution of projects supported by FINEP (FNDCT) in detail: 1975/78, 15 projects; 1979/82, 13 projects, five of which had their development hampered by the discontinuity of financing; 1983/86, 47 projects. In total, 75 projects from 31 institutions were financed by FINEP.

TEIXEIRA (1985, p. 103, 104) points out that 58 studies on Collective Health were supported in 1975-1979, “whereas in 1968-75, only 29 projects had

been supported.” Teixeira states that the institution’s financial support was to be granted in the late 1960s, and also mentions that, in 1978, the “Integrated Health Program” was formulated by FINEP to strengthen research and emerging centers, but this initiative did not take place, and “support will only resume in 1982, focusing on the social health sciences”. The author also mentions that the Integrated Program for Endemic Diseases, inserted in the field of Collective Health, developed more than 200 projects, but that due to the approaches used (clinical-epidemiological, therapeutic, immunological, among others), “they [the projects] are more properly situated in the traditional area of public health research, and not in the area currently known as Collective Health.”

NOVAES; NOVAES (1996, p.46) highlight that these “pioneering initiatives will seek to guide research activity with more specifically social purposes.” FINEP appears as the first instrument of this “new policy of S&T in Collective Health”. These authors refer to “the creation and consolidation of research groups and definition of study objects and lines of investigation” in the political process of ‘institutional support’, with allocation of substantial resources to PESES/PEPPE and the Institute of Social Medicine of the State University of Rio de Janeiro (UERJ).

According to RIBEIRO (1991, p. 126, 127), the resources were destined “for the improvement in health ‘control’ instruments and in medical care”; [...] to carry out a “constant and meticulous investigation of this reality”; [...] and to “harmoniously develop the most appropriate technological instruments”; “[...] evidently, the instruments are provided by the social sciences.” The author also mentions that the participation of the social sciences in the budget of the Department of Social and Regional Development of FINEP – responsible for the field of social sciences – grows systematically in 1974-1979 – from 1.1% in 1974 to 17.4% in 1979.

In 1984 (21-19/August, in Nova Friburgo), at the Evaluation Meeting of the FINEP/CNPq Collective Health Program, the topics addressed were: the “need to optimize existing resources” and the “possibility of organized participation of researchers in the field of collective health in this process,

through ABRASCO" (p. 47), the development process of which happened throughout the 1980s. Novaes; Novaes (1996, p. 48, 49) note that this moment "also meant the end of the 'model' of scientific policy in force in the field of Collective Health since 1979." With the decrease in resources, the Collective Health Program (PSC) was disbanded.

4. 1979 (27/September) – 1st Meeting on the Training and Use of Higher Education Personnel in the Field of Collective Health, held in Brasília, promoted by the ministries of Education, Health, Welfare and Social Assistance and the Pan American Health Organization, coordinated by Guerra Macedo, in which ABRASCO (Brazilian Association of Postgraduate Studies in Collective Health) was created, later renamed, in 2011, to ABRASCO (Brazilian Association of Collective Health). In the same year, in October, the 1st Symposium on National Health Policy was held by the Chamber of Deputies, an event that brought together the main leaders of the various trends of the movement in favor of SUS (Brazilian Unified Health Service).

3.2. Origin and Development of Courses in Collective Health

Following the historical evolution of academic postgraduate courses, the first courses falling under the general rubric of Collective Health began taking place in the 1970s, with different denominations (public health, community medicine, social medicine). The first courses created were as follows: 1970 – School of Public Health of USP/SP; 1971 – School of Medicine of USP/Ribeirão Preto; 1973 – School of Medicine of USP/SP; 1973 – School of Medicine of UFBA; 1974 – Master's Program in Social Medicine of the Institute of Social Medicine at UERJ. Three master's courses in Public Health of the National School of Public Health (ENSP), initiated in 1967 and 1968, interrupted in 1969 and reopened in 1977, can be cited as antecedents.

According to BARATA (2015, p. 172-175), in the 1980s, the courses were as follows: five collective health programs that offered master's and doctoral courses, three in São Paulo, one in Rio de Janeiro and one in Salvador; three master's courses, two in Rio de Janeiro, one in Collective Health and one in Women's and Children's Health, created in 1988, at the

Fernando Figueiras Institute – IFF (the doctoral course was created in 1996); and the master's course in Epidemiology of Unifesp, created in 1989 and discontinued in 2005.

The data for 1990-1999 points to the existence of 15 postgraduate programs (14 master's and five doctoral programs), with the following names: Collective Health (9), Epidemiology (2), Public Health (4). In summary, from the end of the 1990s to 2013, there were 33 graduate courses under the general rubric of Collective Health, 23 of which were master's programs, and 10, doctoral programs (BARATA, 2015, p.175). It should also be added that, since 1990, 40 professional master's courses have been opened and, in 2018, two professional doctoral programs were approved by CAPES.

In 2020, the field of Collective Health had a total of 94 programs, 52 of which were academic (14 master's, 2 exclusively doctoral, and 36 master's and doctoral programs.) Bachelor's degrees were already being offered in 22 undergraduate courses.

4. Contributions of Collective Health

The breadth reached by Collective Health has made it difficult to delimit its "borders", using the expression employed by Bourdieu (VIEIRA-DA-SILVA, 2018, p.226), which may also be said in relation to its contributions. According to Vieira-da Silva, Bourdieu preferred the term "borders" over "limits". THIRY-CHERQUES (2006, p. 35,36), referring to BOURDIEU's text (1987, p. 124) on limits, express the following:

> What determines the existence of a field and marks its **limits** are specific interests, the economic and psychological investments it demands from agents with a *habitus* and the institutions within it. What determines life in a field is the **action of individuals and groups**, constituted and constituents of power relations, who invest time, money and work, the return on which is paid depending on the particular economy of each field (emphasis added).

At the general level, the importance of Collective Health can be summarized in a threefold dimension: theoretical-critical, political-sanitary and pedagogical-professionalizing, corresponding to the academic, political and

public perspectives. According to VIEIRA-DA-SILVA (2018, p. 227), “in its genesis, not all the elements that would allow its characterization as a field were given [...]”, but those that were present “made it possible to consider it as a field in the process of obtaining autonomy [...]”. For the author, the three facets that make up the field are: ‘market’, ‘state bureaucracy’ and ‘academia’.

In a simplified way, it can be said that Collective Health seeks to treat health as a social production, which includes teaching subjects and themes that reveal health-society relations; acting as a core of resistance in the country’s re-democratization process, when the 1st Symposium on National Health Policy was held, in October 1979, with the presentation of the document “The democratic issue in the field of health” (CEBES, 1979); being a reference in the Brazilian Health Reform and in the creation of the Brazilian Unified Health System (SUS) due to its “mutual influences,” using the expression employed by LEAL (2015, p. 196); having become central to graduate and post-graduate education in the field of health sciences and its socio-anthropological aspects; and having been structured based on a double vocation, as “a political project of transforming intervention in the healthcare system and services [...]” and “a project for the production of a critical theory of health, which is also politically engaged, [...] focused mainly on the development of studies and research for the consolidation of a new interdisciplinary field of scientific production, [...] articulating the social sciences with the health sciences [...]” RIBEIRO (1991, p. 148, 149).

At the **postgraduate level**, several studies have shown the importance of Collective Health when associated with its threefold dimension: epidemiology, social and human sciences in health, planning, management, and administration. Although each dimension has specific aspects related to different theoretical, methodological and applied frameworks, as a whole, Collective Health reveals itself as interdisciplinary (characterized by authors either as multidisciplinary or transdisciplinary), using quantitative and qualitative, synchronic and diachronic, objective and subjective methodologies.

A trait that causes Collective Health to stand out amidst the fields of knowledge is the great diversity of **themes addressed**. Taking as reference the

12th Brazilian Congress on Collective Health, held from July 26 to 29, 2018, in Rio de Janeiro, 4,491 papers and 32 thematic axes were presented. The high number of thematic axes reveals the diversity of the contribution of Collective Health to different areas of knowledge and their interconnections. I have listed the first twelve axes and calculated the percentages (ABRASCO. 2019). The category Others ranks first, with 729 axes (16.2%), followed by Health Education and Training, with 608 (13.5%); Health Planning, Management and Evaluation, with 315 (7.0%); Food and Nutrition in Health, with 275 (6.1%); Mental Health, Alcohol and Other Drugs, with 271 (6.0%); Organization of Health Care, Models, Networks, and Regionalization of Health, with 227 (5.0%); Communicable Diseases, with 223 (4.9%). Health and Life Cycles, with 216 (4.8%); Production, Labor and Occupational Health, with 201 (4.4%); Chronic Diseases and Aggravations, with 197 (4.3%); Health Surveillance, with 183 (4.0%); and Gender, Sexuality and Health, with 171 (3.8%).

Regarding the **Brazilian production** in relation to the world production and its internationalization, the **Activities Report** (Collective Health) of 2017 on the SJR portal points out the following, comparing the 2003-2005 and 2013-2015 trienniums:

> The Brazilian production in Health Policy, for example, went from the 26th to the 7th position in the production of scientific articles worldwide, representing 3.2% of this production in the 2013-2015 triennium. The participation of the national production in Public Health, Environmental Health and Occupational Health and in Epidemiology compared to the world production doubled in the period, while in the area of Social Health Sciences, it was seven times as great (p. 39).

The **internationalization** of the field can also be verified in the following quote:

> Based on Scival®, the existence of Brazilian collaboration to the field of Collective Health was identified, amidst the researchers from 138 countries and the 1603 unique publications and those with international co-authorship published between 2013 and 2015. It is interesting to note that this set of publications had an average of 4.8 citations per article, while the number of citations per article was 2.3 when considering all the publications on Collective Health in this period. This aspect reinforces the visibility of research resulted from international collaboration (p. 40).

A point to be highlighted in relation to the contributions of Collective Health, but which still needs to be deepened due to the small number of

studies, pertains to **post-graduates and their activities**. As a review of the subject is not the objective of this article, the consultation was based only on the SciELO database (06/04/2020), in which 89 texts were found using the descriptor *post-graduates*; when adding the descriptor *collective health*, this number fell to only 11. In general, they concern the profiles of post-graduates, and not the activities developed after receiving a graduate degree. There are other types of documents (theses, books) addressing this issue, including the DAC Technical Report (CAPES, 2017), but which will also not be discussed in this article. In the aforementioned Technical Report, the following statement is found:

> There is an understanding [...] that an expressive contingent of doctors graduate in the Humanities, which include the Human Sciences, the Applied Social Sciences, Letters and Arts, followed by the Health and Biological Sciences, with proportionally far fewer doctors in Engineering (p. 10).It goes on to state:

> In general, we can identify a difference in the profile of those holding academic and professional master's degrees [...] professional master's programs seem to absorb a contingent of graduates inserted in the labor market, who aim to enhance their vocational training (p. 10).

In relation to **professional insertion**, I analyze the research carried out within the Graduate Program in Collective Health of FCM at Unicamp (PPG-SC), a cross-sectional study that took place between June and December 2016 (GÓMEZ LA-ROTTA; BARROS; DONALÍSIO, 2017, n.p.) The population studied was made up of all professionals who had joined and completed the program between 1991 and March 2016, totaling 745 professionals (between 1992 and 2016), 370 in the master's program and 345 in the doctoral program. It was found that 549 had completed the program (308 – 56.1% corresponding to the master's program and 241 – 43.9% to the doctoral program), of whom 378 (68.7%) were women. The sociodemographic characteristics of the professionals and their trajectories and production were evaluated. The authors point out, regarding the background of the professionals and their destination after concluding the postgraduate course: "most came from the Southeast region, with 185 in the doctoral program (79.1% of the total) and 168

in the master's program (88% of the total); among these, after the defenses, 17 (9.2%) of those in the doctoral program and 10 (5.9%) of those in the master's program moved to other regions of Brazil, mainly in the South and Midwest"; "The North and Northeast regions received back all those enrolled in PPG-SC, and three more doctors migrated to Higher Education Institutions in the Northeast." In relation to **professional insertion**, the data revealed that there was a change in the activity of the graduates, in the period of 1992-2016, before and after completing the program, with an increase in the percentage of professionals who switched to teaching and research activities upon receiving a graduate degree. The increase in teaching activities among doctors was of 63.6% before admission to 75.6% after completing the program, while the increase in research activities was of 23.8% to 61.9%. Health care activities decreased among those who had completed the program. The data for the last five years shows that 66.9% of post-graduates work as professors; 45.26% as researchers; 38.7% as health care providers, and 28.8% as managers, and also that there are more holders of master's degrees working as professors (57.6%) and health care providers (51.5%), and only 28.6% as researchers, while 78.3% of doctors work as professors and 65.22% as researchers; additionally, more than 50% and 25.4% of those holding a master's degree work in care and management, respectively, compared to 30.1% of doctors acting as managers and 23.9% as health care providers, at the following levels: 65.4% – municipal; 8.2% – state; 23.6% – federal and 2.7% – international (PAHO, WHO, UN)

Regarding **continuing education**, 10.9% (57) of the post-graduates enrolled in a post-doctoral program, the majority (43.9%) in the subarea of Policies, Planning and Management; 46.3% took courses abroad (Argentina, United States, England, Italy, France, Spain and Portugal) and 53.7% in the country, 18.5% (10) at Unicamp.

Although the example refers to a case study, which cannot be generalized to graduate courses in collective health, it shows the potential of professional trajectories and insertion in this field. OLIVEIRA; SILVA (2015, p. 90, 91)

conclude that the main field of work of those holding an undergraduate or graduate degree in collective health is the public sector.

To finish analyzing the contributions of Collective Health to Postgraduate Studies, it is necessary to mention the fact that it is an area with more than a dozen journals, two of which are official ABRASCO publications – *Ciência & Saúde Coletiva*, created in 1996, and *Revista Brasileira de Epidemiologia*, created in 1998.

In less than three decades, *Ciência & Saúde Coletiva* has achieved a high status among publications:

> Upon reaching its 25th anniversary, *Ciência & Saúde Coletiva* has a lot to celebrate! Today, it can be accessed through 22 national and international databases [...] (www.cienciaesaudecoletiva.com.br) and is also present on social networks: Facebook, Twitter and Instagram. In 2019, it maintained its leading position on Google Scholar as the most cited Brazilian journal in all areas of knowledge in the country. [...] its impact factor on Web of Science was of over one point, reaching 1.008! [...] in 1919, it received an international award, the Research Excellence Award Brazil, granted by the Web of Science Group, which belongs to Clarivate Analytics. The initiative recognized the good performance of Brazilian research, and the Journal was nominated in the category "SciELO Citation Index Award" (MINAYO; GOMES; SILVA, 2020. p. 780.)

MINAYO (2020, n.p.) has recently written an extensive narrative about the Journal, celebrating its 25 years:

> The Journal's vision for the future remains linked to its improvement, to the ethics of scientific dissemination, and to internationalization breakthroughs. Its parameters, in addition to the conventional academic standards, are associated with the editorial transformations that open science requires, on the one hand; and the popularization of science, on the other. These are the foci of investment of the present, to be extended to the future.

In order to address the various thematic fields, specific articles on the production of the Journal in these 25 years have been developed by experts, mentioning: the narrative field, health promotion and quality of life, history, science and collective health, food and nutrition in Brazil, scientific production of Epidemiology, gender and health, chronic diseases, pharmaceutical assistance, qualitative approaches, violence, occupational health, primary care.

In turn, *Revista Brasileira de Epidemiologia*, launched in the late 1990s, “found its roots in the development, growth and consolidation of the academic field in Brazil” (MINAYO, GOMES; ALMEIDA; GOLDBAUM; CARVALHEIRO 2015, p. 109). In addition to regular publication, the journal has dedicated itself to addressing theoretical and methodological issues of national interest.

Final Considerations

One of the nineteen professions that make up the Health Sciences, Collective Health has completed its institutionalization process, officially initiated in 1979, in a relatively short time, four decades.

Its scope and theoretical, political and applied guidelines are a reference for not only the health community, but also for the most diverse disciplines – education, planning, social sciences, humanities, medicine, nutrition, speech therapy, physiotherapy, occupational therapy, dentistry, physical education, among many others.

It has been attracting thousands of participants to its Congresses, such as the 1st National Congress of Abrasco/2nd Congress on Public Health of São Paulo, with 2000 participants, from April 17 to 21, 1983; the 1st Brazilian Congress on Collective Health, held in Rio de Janeiro from September 22 to 26, 1986, with 2000 participants; and the 12th Congress, held in Rio de Janeiro from 26 to 29 July 2018, with more than 8000 participants.

The subareas, too, have been organizing their own congresses: Epidemiology held 10 congresses (the 11th was postponed due to the COVID19 pandemic); the Social and Human Sciences held eight congresses, the last one in 2019; and the area of Health Policy, Planning and Management held three congresses, the fourth of which, planned for 2020, was postponed for the above reason, namely, the pandemic.

It is important to mention the relevant role that Collective Health has been playing, through ABRASCO, at a time when the world is being plagued by a pandemic. In June 2020, *Ciência & Saúde Coletiva* launched a thematic issue on COVID-19. Other journals in the area also edited special issues about the epidemic.

In addition to the publications, ABRASCO held a series of events: live programs, videos, interviews, and analyses addressing different subjects with the presence of researchers, professors and specialists in the field of Collective Health, of which **Ágora Abrasco** stands out, consisting in the "programming of diversified activities transmitted on the internet with the aim of following the development of the pandemic, understanding the phenomenon, and proposing responses". All this work and dedication, including that of all frontline professionals, is deserving of a quote by Camus (1913-1960):

> I know of the right science (yes, Rieux, I know everything about life, as you can see), that each person has the plague in them, because nobody, no, nobody in the world is exempt from it. I also know that it is necessary to watch yourself without rest so as not to be led, in a minute of distraction, to breathe on the face of another and transmit the infection to him. What is natural is the microbe. The rest – health, integrity, purity, if you like – is an effect of the will, of a will that must never be stopped (CAMUS, 2017, p. 174,175).

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ABSTRACT

Collective Health: contributions to Brazilian postgraduate education

Abstract This article briefly analyzes postgraduate studies and their history 55 years after the Sucupira Report, number 997/65, and the unique contribution of Collective Health not only to the field of health sciences, but also to graduate education as a whole. It is based on the literature in general and that specifically developed in the field of Collective Health and related areas – epidemiology, social health sciences, and planning. The article first addresses the historical aspects of graduate studies, then the concept of Collective Health and its historical, institutional and pedagogical trajectory, and finally, its contributions.

Keywords: Sucupira Report; Graduate Courses; Collective Health; Social History; Institutionalization

RESUMEN

Salud colectiva: contribuciones a la educación de posgrado brasileña

Resumen Este artículo analiza brevemente los estudios de posgrado y su historia a 55 años del Informe Sucupira, número 997/65, y la contribución única de la Salud Colectiva no solo al campo de las ciencias de la salud, sino también a la educación de posgrado en su conjunto. Se basa en la literatura en general y específicamente desarrollada en el campo de la Salud Colectiva y áreas afines: epidemiología, ciencias sociales de la salud y planificación. El artículo aborda primero los aspectos históricos de los estudios de posgrado, luego el concepto de Salud Colectiva y su trayectoria histórica, institucional y pedagógica, y finalmente, sus aportes.

Palabras clave: Informe Sucupira; Cursos de postgrado; Salud Colectiva; Historia social; Institucionalización

RESUMO

A Saúde Coletiva: contribuições para a pós-graduação brasileria

Resumo Após 55 anos do Parecer Sucupira, número 997/65, este artigo analisa brevemente a pós-graduação e sua história e a contribuição especial e diferenciada da Saúde Coletiva, não apenas no campo das ciências da saúde, mas também na pós-graduação como um todo. O artigo baseia-se na literatura em geral e especificamente para o campo da Saúde Coletiva e áreas conexas - epidemiologia, ciências sociais em saúde e planejamento. O artigo aborda primeiro aspectos históricos da pós-graduação, depois o conceito de Saúde Coletiva e sua trajetória histórica, institucional e pedagógica e, finalmente, suas contribuições.

Palavras-chave: Parecer Sucupira; Cursos de Pós-Graduação; Saúde Coletiva; História Social; Institucionalização

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