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Career commitment and career entrenchment among Primary Health Care workers

Comprometimento e entrincheiramento com a carreira em trabalhadores da Atenção Primária à Saúde

Compromiso y afianzamiento con la carrera del personal de la Atención Primaria de Salud

Luciano Garcia Lourenção[I]
ORCID: 0000-0002-1240-4702

Jacqueline Flores de Oliveira[I]
ORCID: 0000-0002-0598-3881

Francisco Rosemiro Guimarães Ximenes Neto[II]
ORCID: 0000-0002-7905-9990

Carlos Leonardo Figueiredo Cunha[III]
ORCID: 0000-0002-1891-4201

Sandra Verónica Valenzuela-Suazo[IV]
ORCID: 0000-0002-1308-4835

Márcio Andrade Borges[I]
ORCID: 0000-0002-4597-2597

Cláudia Eli Gazetta[V]
ORCID: 0000-0002-2603-8803

[I] *Universidade Federal do Rio Grande. Rio Grande, Rio Grande do Sul, Brazil.*
[II] *Universidade Estadual Vale do Acaraú. Sobral, Ceará, Brazil.*
[III] *Universidade Federal do Pará. Belém, Pará, Brazil.*
[IV] *Universidad de Concepción. Concepción, Bío-Bío, Chile.*
[V] *Faculdade de Medicina de São José do Rio Preto. São José do Rio Preto, São Paulo, Brazil.*

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Corresponding author:
Luciano Garcia Lourenção
E-mail: lucianolourencao.enf@gmail.com

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ABSTRACT

Objective: Assess levels of career commitment and career entrenchment among Primary Health Care workers. **Methods**: This Cross-sectional study addressed 393 workers using the Brazilian versions of the Career Commitment Measure (CCM) and Career Entrenchment Measure (CEM). **Results:** Levels of Career commitment [75.5–77.5] were higher (p<0.001) than Career Entrenchment [66.7–69.2]. Identity levels [82.7–85.5] were higher (p<0.001) than Investment levels [60.4–65.0]. Career resilience levels [75.1–79.2] were higher (p<0.001) than Emotional costs [69.0–72.1]. Planning levels [64.2–67.1] were lower (p<0.001) than levels of limitedness of career alternatives [68.1–71.0]. **Conclusion:** The highest scores were obtained in Career commitment, showing the workers' identification and positive relationship with their careers, that is, these workers remain in Primary Health Care services because they identify themselves with their professions.
Descriptors: Career Mobility; Primary Health Care; Employment; Health Personnel; Occupational Health.

RESUMO

Objetivo: Avaliar os níveis de comprometimento e entrincheiramento com a carreira de trabalhadores da Atenção Primária à Saúde. **Métodos:** Estudo transversal com 393 trabalhadores, utilizando as versões brasileiras das Escalas de Comprometimento com a Carreira (ECC) e de Entrincheiramento na Carreira (EEC). **Resultados:** Os níveis de Comprometimento [75,5 – 77,5] foram superiores (p<0,001) aos de Entrincheiramento [66,7 – 69,2]. Os níveis de Identidade [82,7 – 85,5] foram superiores (p<0,001) aos níveis de Investimentos [60,4 – 65,0]. Os níveis de Resiliência com a carreira [75,1 – 79,2] foram superiores (p<0,001) aos níveis de Custos emocionais com a carreira [69,0 – 72,1]. Os níveis de Planejamento [64,2 – 67,1] foram inferiores (p<0,001) aos níveis de Limitação de alternativas [68,1 – 71,0]. **Conclusão:** Predominou o vínculo de comprometimento com a carreira, evidenciando identificação e relação positiva dos trabalhadores com a carreira, os quais permanecem na Atenção Primária à Saúde porque se identificam com a profissão.
Descritores: Mobilidade Ocupacional; Atenção Primária à Saúde; Emprego; Pessoal de Saúde; Saúde do Trabalhador.

RESUMEN

Objetivo: Evaluar los niveles de compromiso y afianzamiento con la carrera del personal de la Atención Primaria de Salud. **Métodos:** Se trata de un estudio transversal, realizado entre 393 trabajadores, en el que se utilizaron las versiones brasileras de las Escalas de Compromiso con la Carrera (ECC) y de Afianzamiento con la Carrera (EEC). **Resultados:** Los niveles de Compromiso [75,5 – 77,5] eran superiores (p<0,001) a los de Afianzamiento [66,7 – 69,2]. Los niveles de Identidad [82,7 – 85,5] eran superiores (p<0,001) a los de Inversión [60,4 – 65,0]. Los niveles de Resiliencia con la carrera [75,1 – 79,2] eran superiores (p<0,001) a los de Costo emocional [69,0 – 72,1]. Los niveles de Planificación [64,2 – 67,1] eran inferiores (p<0,001) a los de Limitación de alternativas [68,1 – 71,0]. **Conclusión:** Predominó el vínculo de compromiso con la carrera, lo que demuestra una identificación y relación positiva de los trabajadores con la misma y permanecen en la Atención Primaria de Salud porque se identifican con la profesión.
Descriptores: Movilidad Laboral; Atención Primaria de Salud; Empleo; Personal de Salud; Salud Laboral.

INTRODUCTION

In Brazil, the large contingent that makes up the workforce of Primary Health Care (PHC) workers experiences intense social and labor vulnerability. The literature reports the precarious working conditions of these workers, with weak or temporary job contracts, low salaries, not job position or salary plans, increased outsourcing, high turnover, and illnesses. All these factors compromise the problem-solving capacity of the Brazilian Unified Health System (SUS)[1-2].

In this context, the work process of PHC services has growing demand and scope of practices that incorporate new responsibilities every day, causing workers to experience overload and exhaustion. This situation may lead to job dissatisfaction, frustration, and apathy, resulting in a conflicting situation among those workers who believed they would develop and feel satisfied and fulfilled with their jobs[3-5].

This context affects how these workers relate to their careers. For this reason, it is vital to understand how PHC workers are connected with health services. Career commitment and career entrenchment emerge among motivated workers and include divergent behaviors that can cause significant social, organizational, personal, and sanitary impacts [6-7].

Career commitment consists of a positive relationship established between workers and their professions and may give meaning and continuity at work. Committed workers become involved with their organization, jobs, careers and desire to remain and grow in their careers and overcome obstacles[7-8].

On the other hand, career entrenchment means a worker is stagnated in a job position for not having alternatives, fear of losing previous investments, and attempts to avoid potential emotional costs from changing careers. Hence, workers tend to remain in a career, even if dissatisfied, due to previous investments, emotional loss accruing from changing careers, and having no career prospects[7-9].

Career commitment and career entrenchment explain the intention and persistence of workers in the course of action that delimits their occupation and investments to construct a successful personal trajectory that also benefits society. Possibly, career entrenchment does not depend on one's level of commitment; that is, entrenchment and commitment would be different and independent, but not opposing relations, though with different impacts on one's performance[6,10-11].

The Brazilian literature addressing career commitment and career entrenchment is incipient, especially among PHC workers. One study addressing nurses working in hospital settings reports that most are committed to their careers. Such a commitment, explaining why these workers remain in the nursing profession, may be associated with the fact they identify themselves with the profession[7].

International studies addressing health workers report high levels of career commitment, showing that age, the field of work, and years of experience interfere in commitment levels[12-13].

OBJECTIVE

To assess levels of career commitment and career entrenchment among PHC workers.

METHOD

Ethical aspects

Data collection was initiated after the Institutional Review Board at the Medical School of São José do Rio Preto approved the study.

Study design, period, and settings

This cross-sectional, descriptive, and analytical study was conducted in 2018 in two cities in the state of São Paulo, Brazil, addressing a non-probabilistic, convenience sample composed of PHC workers.

The first city (city A) is located in the north of the state of São Paulo, 452 km from the capital. According to the Brazilian Institute of Geography and Statistics (IBGE), it is a large city with an estimated population of 438,354 inhabitants. This city hosts the 15th Regional Health Division, the largest in the state of São Paulo, and is a reference in healthcare.

At the time of data collection, the city was divided into five Health Districts. PHC was responsible for 27 municipal services: 10 Basic Health Units (UBS) and 17 Family Basic Health Units (UBSF), with 40 Family Health Strategy (ESF) teams, covering 24% of the population.

The second city (city B) is located in the state's western region, 596 km from the capital. It is a small city, with 33,707 inhabitants. The city is a reference in the health field for nine cities in the Nova Alta Paulista region. According to the local healthcare structure, PHC was provided by four Basic Health Units (UBS), with ten ESF covering 100% of the population.

Population and sample: inclusion and exclusion criteria

The study's population was 549 workers composing the cities' ESF teams (i.e., nurses, physicians, nursing technicians and aids, and Community Health Agents – CHA): 410 in city A and 139 in city B. Those working in ESF teams for at least six months were included in the study. Workers on vacation or any kind of leave during the period of data collection were excluded from the study. The convenience sample was composed of 393 ESF workers.

Study protocol

Three instruments were used to collect data: a form addressing sociodemographic and occupational variables such as sex, age, education, marital status, family income, type of job contract, whether the worker was the head of the unit, years of experience in PHC; the Brazilian version of the Career Commitment Measure (CCM) by Carson and Bedeian[8,14]; and the Brazilian version of the Career Entrenchment Measure (CEM), developed by Carson, Carson and Bedeian[9,15].

CCM is composed of 12 items, distributed into three factors: identity, resilience, and planning. The items are statements that describe attitudes and behaviors toward one's career[8,14]. CEM is also composed of 12 items, distributed into three factors: career investments, emotional costs, and limitedness of career alternatives. The CEM items describe perceptions and feelings

toward the possibility of changing careers[9,15]. These measures were validated in Brazil and internationally by researchers from the psychology, administration, and related fields.

Agreement in both measures is rated on a 5-point Likert scale ranging from 1=strongly disagree; 2=disagree; 3=neither agree, nor disagree; 4=agree; and 5=strongly agree.

Data collection was scheduled with the health units' managers and conducted during the teams' meetings. After the authors provided clarification regarding the study's objectives, the workers who consented to participate signed free and informed consent forms. After the participants completed the questionnaires, they returned them in unidentified envelopes to ensure the participants' identities would remain confidential. Some participants opted to fill out the questionnaires later, so a date was scheduled to return the completed instruments (approximately one week later).

Data analysis and statistics

Data were analyzed with SPSS, version 23.0. Descriptive (central tendency and dispersion measures) and exploratory analyses were performed to verify data accuracy, distribution of missing cases, sample size, and sample description. Cronbach's alpha was used to verify the reliability of the measures of the theoretical constructs used in the questionnaire. The following values were found: career commitment α=0.795 and career entrenchment α=0.792, both considered good reliability indicators[16].

The sociodemographic and occupational data were used to characterize the study's population. The mean score and standard deviation of the constructs were calculated on a scale from zero to 20 for each factor (identity, planning, and resilience; investments, limited alternatives, and emotional costs) and from zero to 60 for commitment and entrenchment, to verify the workers' relations with their careers. The means of each factor/construct were standardized on a scale from zero to 100 and classified into three categories, according to the mean score: low (zero to 33.3), moderate (33.4 to 66.7), and high (66.8 to 100.0).

The levels of career commitment and career entrenchment established between the workers and their careers were compared between the two cities using the t-test. Finally, the difference between these was verified according to sociodemographic and occupational variables, using the two-sample t-test or analysis of variance (ANOVA) for three or more means, with the significance level established at 95% ($p \leq 0.05$).

RESULTS

Table 1 shows the distribution of the workers' sociodemographic and occupational profiles per city. Of the universe of workers listed for this study, 393 (71.6%) were selected, 313 (76.3%) were from city A and 80 (57.6%) from city B. The largest contingent of workers was Community Health Agents, representing 45.0% of the study's total participants. Most workers were women (80.9%), aged between 31 and 45 years old (46.6%), with high school (49.1%), hired through a public competition process (76.6%), worked in health care (87.3%), had an income between two and five times the minimum wage (61.6%), and worked in the PHC service between one and two years (36.4%).

Table 2 shows the analysis of career commitment and career entrenchment. No significant statistical differences were found between the workers in the two cities. High scores were obtained in most factors for both constructs (career commitment and career entrenchment), except for the Planning factor, in which the workers from city A obtained a moderate score (65.0) and the workers from city B obtained high scores (68.2). The workers in both cities obtained moderate scores in the Investments factor (63.0 and 61.7 for cities A and B, respectively).

The levels of Career commitment [CI95%: 75.5–77.5] presented by the PHC workers were higher (p<0.001) than Career entrenchment levels [CI95%: 66.7–69.2]. Likewise, the levels of Career identity [CI95%: 82.7–85.5] were significantly higher (p<0.001) than levels of Career investments [CI95%: 60.4–65.0], while Career resilience levels [CI95%: 75.1–79.2] were statistically higher (p<0.001) than Career emotional costs [CI95%: 69.0–72.1]. However, the scores [CI95%: 64.2–67.1] obtained in Career planning were significantly lower (p<0.001) than the scores obtained in Limitedness of career alternatives [CI95%: 68.1–71.0].

Table 1 – Sociodemographic and occupational characteristics of Primary Health Care workers according to city

Variables	City A n (%)	City B n (%)
Total	313 (100.0)	80 (100.0)
Occupation		
Physician	32 (10.2)	9 (11.3)
Nurse	77 (24.6)	15 (18.8)
Nursing aid/technician	71 (22.7)	12 (15.0)
Community health agent	133 (42.5)	44 (55.0)
Sex		
Male	50 (16.0)	21 (26.3)
Female	260 (83.1)	58 (72.5)
No answer	3 (1.0)	1 (1.3)
Age		
21 to 30 years old	47 (15.0)	11 (13.8)
31 to 45 years old	145 (46.3)	38 (47.5)
46 to 60 years old	100 (31.9)	25 (31.3)
61 years old or older	9 (2.9)	-
No answer	12 (3.8)	6 (7.5)
Education		
High School	149 (47.6)	44 (55.1)
Bachelor's degree	67 (21.4)	17 (21.3)
Graduate studies	97 (31.0)	18 (22.5)
No answer	-	1 (1.3)
Type of contract		
Public competition	235 (75.1)	66 (82.5)
Hired	73 (23.3)	14 (17.5)
No answer	5 (1.6)	-
Position		
Administrative	36 (11.5)	10 (12.5)
Care delivery	274 (87.5)	69 (87.6)
No answer	3 (1.0)	-
Family Income (Minimum wage)		
Up to 1 times the M.W.	23 (7.3)	12 (15.0)
From 2 to 5 times the M.W.	185 (59.1)	57 (71.3)
From 6 to 10 times the M.W.	61 (19.5)	6 (7.5)
More than 10 times the M.W.	38 (12.1)	5 (6.3)
No answer	6 (1.9)	-
Experience in PHC (years)		
< 1 to 2	122 (39.0)	21 (26.3)
> 2 to 10	49 (15.7)	30 (37.5)
> 10 to 20	65 (20.8)	12 (15.0)
> 20	62 (19.8)	15 (18.8)
No answer	15 (4.8)	2 (2.5)

*PHC - Primary Health Care; M.W.- Minimum wage; *Minimum wage: R$ 937.00.*

Table 2 – Mean scores and standard deviations for the constructs and dimensions of the relations established between Primary Health Care workers and their careers

Career bonds	City A Mean (±*sd*)	City B Mean (±*sd*)	*p* value
Career commitment	76.5 (9.7)	76.8 (11.2)	0.805
Career identity	84.3 (14.2)	83.4 (14.5)	0.606
Career planning	65.0 (13.7)	68.2 (18.3)	0.078
Career resilience	77.6 (20.4)	75.6 (20.5)	0.456
Career entrenchment	67.7 (12.1)	68.7 (13.9)	0.530
Career investments	63.0 (22.5)	61.7 (24.3)	0.654
Limitedness of career alternatives	69.2 (14.5)	71.1 (13.4)	0.289
Career emotional costs	70.1 (15.3)	72.4 (17.8)	0.238

According to sociodemographic and occupational characteristics, the analysis concerning the relations established by the PHC workers with their careers (Table 3) shows that the physicians had a higher level of Career identity (92.4) and Career investments (79.5) than the remaining workers. At the same time, CHA presented the lowest levels of Career identity (79.0) and Career investments (52.3), and the nurses were the professionals who presented the highest level of Limitedness of career alternatives (73.4).

Younger workers presented the lowest level of Career identity (78.8) and the highest level of Career resilience (80.8). Those with a graduate degree experienced the highest level of Career identity (88.4), Career investments (74.0) and Limitedness of career alternatives (73.6), and the lowest level of Career planning (63.0).

The workers hired through public competition presented the lowest level of Career identity (82.4), with higher levels of Career planning (66.8) and Career resilience (79.3) than hired workers ($p<0.05$). Those holding a manager position in the UBS presented higher levels of Career identity (87.4), Career investments (73.0), and Limitedness of career alternatives (72.5) than those working with care delivery.

Additionally, the higher the income, the higher the levels of Career identity ($p=0.040$) and Career investments ($p=0.002$) and the lower the level of Career planning ($p=0.039$). Workers with lower incomes (up to one times the minimum wage) or very high incomes (above six times the minimum wage) presented the highest levels of Limitedness of career alternatives ($p=0.000$).

Table 3 – Distribution of mean scores and standard deviations for the constructs and dimensions of the career relationships, according to the Primary Health Care workers' sociodemographic and occupational characteristics

Sociodemographic and occupational variables	Career Commitment				Career Entrenchment			
	Identity	Planning	Resilience	General construct	Investments	Limited alternatives	Emotional costs	General construct
Profession								
Physician	92.4 (10.7) [b]	61.7 (10.4) [a]	72.4 (22.9) [b]	76.6 (9.4) [b]	75.9 (25.5) [b]	71.3 (15.2) [b]	67.1 (17.2) [b]	72.6 (15.7) [b]
Nurse	87.2 (10.1) [b]	63.5 (13.1) [a]	77.1 (20.6) [b]	76.7 (8.5) [b]	71.4 (21.5) [b]	73.4 (10.5) [b]	71.2 (12.7) [b]	72.3 (9.4) [b]
Nursing technician/Aid	87.4 (11.7) [b]	68.0 (15.3) [b]	75.6 (20.8) [b]	77.8 (10.5) [b]	68.9 (21.6) [b]	71.2 (16.3) [b]	68.9 (14.8) [b]	69.9 (12.2) [b]
Community health agent	79.0 (16.0) [b]	66.6 (16.0) [a]	79.0 (19.4) [b]	75.8 (10.7) [b]	52.3 (18.7) [a]	66.4 (14.2) [a]	71.8 (17.4) [b]	63.7 (11.8) [a]
p value	0.000	0.054	0.250	0.533	0.000	0.001	0.247	0.000
Age								
21 to 30 years old	78.8 (17.8) [b]	66.0 (15.8) [a]	80.8 (18.4) [b]	76.3 (9.0) [b]	56.5 (24.5) [a]	66.3 (14.9) [a]	71.8 (15.2) [b]	65.1 (13.0) [a]
31 to 45 years old	84.6 (13.6) [b]	64.7 (15.0) [a]	78.6 (19.8) [b]	77.0 (9.8) [b]	63.9 (22.2) [a]	71.0 (12.6) [b]	70.7 (15.1) [b]	68.9 (11.7) [b]
46 to 60 years old	85.1 (13.2) [b]	66.8 (13.8)	74.3 (20.7) [b]	75.9 (10.4) [b]	63.6 (22.7) [a]	68.6 (15.6) [b]	69.6 (16.4) [b]	67.6 (13.1) [b]
61 years old or older	91.0 (14.4) [b]	59.0 (11.7) [a]	58.3 (28.8) [a]	70.8 (11.6) [b]	62.5 (25.2) [a]	72.9 (21.4) [b]	75.7 (24.7) [b]	72.0 (16.9) [b]
p value	0.012	0.352	0.005	0.296	0.167	0.116	0.628	0.162
Education								
High School	82.6 (13.7) [b]	67.5 (15.3)	78.4 (20.0) [b]	77.0 (10.8) [b]	58.5 (20.6) [a]	68.6 (15.1) [b]	69.5 (17.0) [b]	65.8 (12.3) [a]
College	82.1 (17.6) [b]	65.5 (14.9) [a]	76.1 (19.6) [b]	75.5 (9.1) [b]	57.2 (23.1) [a]	66.5 (13.7) [a]	71.9 (15.1) [b]	65.4 (12.1) [a]
Graduate studies	88.4 (10.9) [b]	63.0 (13.2) [a]	76.0 (21.7) [b]	76.7 (9.0) [b]	74.0 (22.4) [b]	73.6 (12.2) [b]	71.4 (14.4) [b]	73.6 (11.2) [b]
p value	0.001	0.035	0.547	0.526	0.000	0.001	0.425	0.000
Job contract								
Public competition	82.4 (14.8) [b]	66.8 (15.0)	79.3 (19.7) [b]	77.1 (10.2) [b]	61.5 (21.9) [a]	69.0 (14.2) [b]	71.0 (16.1) [b]	67.4 (12.3) [b]
Hired	89.9 (10.4) [b]	62.0 (13.2) [a]	71.3 (21.2) [b]	75.3 (9.2) [b]	67.5 (25.0) [b]	72.2 (13.7) [b]	69.2 (14.9) [b]	70.1 (12.8) [b]
p value	0.000	0.005	0.001	0.127	0.029	0.056	0.332	0.083
Field of work								
Managerial	87.4 (10.2) [b]	65.4 (14.2) [a]	78.3 (19.0) [b]	78.1 (7.5) [b]	73.0 (18.8) [b]	72.5 (6.9) [b]	68.3 (12.0) [b]	71.5 (7.7) [b]
Healthcare delivery	83.6 (14.7) [b]	65.7 (14.9) [a]	77.1 (20.5) [b]	76.3 (10.3) [b]	61.4 (23.1) [a]	69.2 (15.0) [b]	70.9 (16.3) [b]	67.5 (12.9) [b]
p value	0.031	0.890	0.695	0.172	0.000	0.014	0.194	0.004
Family Income (Minimum wage)								
Up to 1 MW	82.4 (14.1) [b]	70.1 (16.6)	79.3 (18.7) [b]	78.0 (9.8) [b]	57.6 (17.2) [a]	70.1 (12.9) [b]	74.1 (17.9) [b]	67.5 (10.2) [b]
From 2 to 5 MW	82.9 (14.9) [b]	66.0 (15.3) [a]	78.0 (20.0) [b]	76.6 (10.6) [b]	59.3 (22.4) [a]	68.4 (15.0) [b]	70.7 (16.1) [b]	66.3 (12.5) [a]
From 6 to 10 MW	85.7 (12.1) [b]	65.2 (12.5) [a]	75.1 (21.4) [b]	75.9 (8.9) [b]	71.2 (22.5) [b]	73.8 (12.5) [b]	68.6 (12.7) [b]	71.8 (11.6) [b]
More than 10 MW	89.1 (12.9) [b]	60.6 (12.6) [a]	76.2 (21.7) [b]	76.4 (9.1) [b]	74.9 (23.1) [b]	70.1 (12.9) [b]	69.0 (17.0) [b]	72.1 (13.1) [b]
p value	0.040	0.039	0.682	0.794	0.002	0.000	0.056	0.361
Experience in PHC (years)								
< 1 to 2	80.6 (16.9) [b]	64.4 (14.5) [a]	77.6 (20.0) [b]	75.3 (10.6) [b]	53.8 (22.7) [a]	65.8 (14.2) [a]	73.2 (16.3) [b]	64.5 (12.3) [a]
> 2 to 10	87.1 (13.0) [b]	67.0 (15.3)	75.8 (20.1) [b]	77.7 (9.7) [b]	67.3 (21.7) [b]	73.4 (12.5) [b]	72.1 (15.8) [b]	71.4 (12.1) [b]
> 10 to 20	83.8 (12.0) [b]	66.2 (15.2) [a]	79.1 (20.9) [b]	77.0 (10.2) [b]	63.6 (20.4) [a]	71.0 (15.2) [b]	69.3 (15.2) [b]	68.0 (11.8) [b]
> 20	87.5 (11.4) [b]	65.9 (15.4) [a]	75.7 (21.7) [b]	77.1 (9.5) [b]	73.8 (22.0) [b]	71.0 (13.9) [b]	66.9 (15.0) [b]	71.2 (12.7) [b]
p value	0.001	0.638	0.691	0.342	0.000	0.000	0.001	0.031

PHC - Primary Health Care; M.W.- Minimum wage; [a] Moderate level [b] High level

Regarding years of experience in PHC, those working for up to two years presented the lowest levels of Career identity (80.6), Career investments (53.8), and Limitedness of career alternatives (65,8), and higher Emotional costs (73.2).

Levels of Career commitment and Career entrenchment between sexes were equivalent, with no significant differences between men and women (p>0.05).

DISCUSSION

The workers addressed in this study compose the minimum ESF team as recommended by the *Política Nacional de Atenção Básica* (PNAB)[17] [Primary Health Care National Policy], and their profiles corroborate those profiles reported by studies conducted in different Brazilian regions[3-5,18-22].

Most workers were women, ratifying the feminization phenomenon, which has occurred since the 1990s in most professions in the healthcare field, except for the Nursing field, in which masculinization has occurred[23].

High levels of Career commitment show that despite difficulties, the workers have a positive relationship with their professions and find meaning in their practice within PHC services. These results are in line with international studies addressing non-medical workers from the Council of Academic Family Medicine in the United States and Canada[12], and Egyptian[13], and Saudis nurses[24]. However, these levels are higher than those presented by Brazilian nurses working in hospital facilities[7]. The social support provided to workers positively impacts their level of Career commitment[13,24].

However, given territorial and occupational differences as well as differences in lifestyle in the various Brazilian regions, and more flexible labor terms, these positive results do not represent the context of all PHC workers in Brazil[25]. Workers with precarious job contracts are likely to present different results.

Despite the attempts of the *Programa Nacional de Desprecarização do Trabalho* [National Program for Safer Labor Contracts] to strengthen job contracts within SUS to implement humanization policies, effective job contracts, and higher salaries, the *Terceiro Ciclo da Avaliação Externa do Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB)* [Third Cycle of the External Evaluation of the Program for Improvement of Access and Quality of Primary Health Care] shows that approximately 40% of the PHC workers are hired under precarious contracts, with temporary or informal jobs[26-27]. On the one hand, the PHC workers' job stability is associated with a career plan that values professional growth and development, increasing one's level of career commitment. On the other hand, more flexible Brazilian labor laws and consequent precarious job contracts undermine job stability, social rights and worsen the conditions of job contracts, leading to increased levels of career entrenchment[7,12,28].

Additionally, the moderate levels of career planning reveal workers have limited ability to establish goals for career development(7-8), especially among those workers with lower educational levels, such as Nursing technicians and aids and CHA, who in general face more significant financial restrictions. Workers with a college degree, i.e., higher education and higher incomes, have higher levels of investment and emotional loss in case of a career change, leading to higher levels of career entrenchment (stagnation).

Being stagnated in a job position in the current context of labor relations because of a lack of options and unwillingness to lose investments and avoid emotional costs related to career changes may lead to insecurity, low self-esteem, social or affective ruptures, and a feeling of failure. For this reason, workers may limit their roles to merely meet the population's needs and implement actions that effectively meet the community's needs, however compromising the quality and problem-solving capacity of PHC services [28-29].

Considering the sociology of professions, which categorizes the phases of professional life and time since graduation to entering the job market, most of the workers addressed in this study are in the phase of professional maturity. In this phase, workers are prepared to consolidate themselves in the job market because they have the qualification and technical, cognitive, and practical skills fully developed[23,30]. This professional maturity is reinforced by significantly higher levels of career identity among older workers and those with long experience in PHC.

In this context, high levels of career identity confirm that the workers addressed here are emotionally attached to their careers, desire to grow and achieve professional recognition, and the work they perform positively influences their self-esteem. It is a favorable situation because when workers invest in their abilities and knowledge, they focus on their careers, contributing to improved performance[6-8].

High levels of career resilience show that workers can overcome diverse situations faced within PHC, generally associated with organizational and managerial issues such as precarious work conditions, lack of autonomy and professional recognition, a deficit in the number of workers, and work overload[29,31]. Workers with high levels of career resilience can work with the team, and being simultaneously independent and cooperative, essential aspects for meeting the PNAB's guidelines[17].

At the same time, younger workers present higher career resilience, struggle to enter and remain in the job market, have two or three jobs, and simultaneously work in the day and night shifts, leading to exhaustion and distress[32-33]; hence, the need and importance of career resilience among workers.

According to the literature, resilience may represent a new focus on the positivity in the workers' actions when facing challenges and adversities in their daily routine, with the possibility of learning and transformation that may reflect in their practice[29]. Therefore, workers' relationships with their careers are a matter of public health, as these relationships may jeopardize the strengthening of EFS and PHC as the SUS' organizing components. In this sense, job demands that are not equivalent to the PHC workers' abilities, expectations, or needs, thus, encourage entrenchment and undermine commitment, are a modern challenge imposed on workers' health.

Study limitations

This study's limitations include the difficulty in comparing the results with other studies addressing this topic due to a lack of investigations conducted in health facilities, especially among

PHC workers, the fact the study was restricted to two cities in the state of São Paulo, preventing comparisons and discussions concerning different Brazilian regions. Hence, future studies are recommended to address workers from other Brazilian regions to compare career commitment and entrenchment among PHC workers from different contexts and work situations, contributing to deepening discussions about this theme.

Contributions for the nursing field and public health

This study contributes to (re)direct the implementation of public policies that promote the personal and professional development of PHC workers, to consolidate the *Política Nacional de Atenção Básica* [Primary Health Care National Policy], improve the problem-solving capacity of PHC services, and strengthen SUS.

CONCLUSIONS

The relationship presented by most PHC workers was career commitment, showing that the workers more frequently identify and have a positive relationship with their careers, instead of stagnation. This relationship indicates that the workers remain in their careers because they identify themselves with their occupation/profession, are resilient, and are less frequently aware of their potential and limitations.

Regarding career entrenchment, the results show that physicians first consider career investments, lack of professional prospects outside their field of practice, and emotional loss before quitting their professions. Nurses and nursing technicians/aids consider a lack of professional prospects outside their field, careers investments, and emotional costs. Finally, CHA assess emotional costs, lack of professional prospects outside their field, and career investments.

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