Social Work Residency at UFJF: Innovative Experiences of Service-Learning Integration in Primary Health Care of the Unified Health System

Residência em Serviço Social na UFJF: Experiências Inovadoras de Integração Ensino e Serviço na Rede de Atenção à Saúde do Sistema Único de Saúde

Auta Iselina Stephan Souza / Lêda Maria Leal de Oliveira / Marina Monteiro de Castro e Castro / Ana Maria Costa Amoroso Lima / Maria Lúcia Salim Miranda Machado / Maria Regina de Paula Fagundes Netto / Meyriland Dias Amorim Friaça / Anna Claudia Rodrigues Alves

Palavras-chave: Ensino; Residência; Serviço Social; Saúde da Família. Keywords: Education; Residency; Social Work; Family Health.

INTRODUCTION

One of the greatest challenges facing the SUS is overcoming the profound inequalities in health. This entails resizing the State’s role in order to actually bring health policy into effect, starting with the structuring, at a municipal level, of physical-conceptual spaces and the financial-economic and managerial basis for health care services. As regards professional training, the policies and actions that ensure personal choice for comprehensive dedication to the public service need adapting so as to help strengthen the commitment, accountability and relationship of the professionals in relation to the users of the health system.

The principles and guidelines implemented by the Public Health Reform were restricted by the State Management Reform (or counter-reform) with reduced public spending and privatizations, expressed in various formats, such as social organizations and intermunicipal health consortiums. Largely conflicting with the Public Health Reform, these alternatives contradict the principle of regionalization and actually support serious deviations in the SUS model, duly identified in the current health policies of the regional centre municipalities, along with significant advances in the process of decentralization and increased physical access.

1 Doctor in Public Health from ENSP/FIOCRUZ; Associate Professor of the School of Social Services at Federal University of Juiz de Fora, Juiz de Fora, MG, Brazil.
2 Doctor in History from ENSP/FIOCRUZ; Associate Professor of the School of Social Services at Federal University of Juiz de Fora, Juiz de Fora, MG, Brazil.
3 Master in Social Services from UFJF; Assistant Professor of the Fluminense Federal University, Rio das Ostras, RJ, Brazil.
4 Doctor in Social Services from UFRJ; Associate Professor of the School of Social Services at Federal University of Juiz de Fora, Juiz de Fora, MG, Brazil.
5 Specialist in Social Services Applied to Health Care from the UFJF; Social Assistant for the Municipal Health Secretary of Juiz de Fora, Juiz de Fora, MG, Brazil.
6 Social Assistant for the Municipal Health Secretary of Juiz de Fora.
7 Social Assistant at the University Hospital of the Federal University of Juiz de Fora, Juiz de Fora, MG, Brazil.
In light of these complex, contradictory and challenging circumstances, this article demonstrates Social Work training experiences in the Health Care Residency Programs of the Federal University of Juiz de Fora (UFJF). The pioneering creation of such programs, previously restricted to only the classic forms of medical and pharmacist-biochemist training, is officially credited to the Social Service Faculty of UFJF. This is because between the professors and researchers of the health area at this particular academic institution, there was a strong commitment to qualify professionals capable of dealing with the intricate relationship between politics, economics, care quality and management of public health services.

The historical course of this creative movement will be described here, presenting its objectives, forms of intervention and distinctive nature of the experience that dates back 12 years.

The Hospital Residency in Social Work was implemented in 1998 at the University Hospital – Health Care Centre (HU/CAS) with the intention of offering assistance work in hospital, outpatient and primary care services, guiding the residents to help them understand the various levels of complexity in the health system and strengthening the care quality provided to users. The underlying objective was to make use of the theoretical and practical experience of the hospital residency program to provide a space for training improvement, both in relation to health policy management and the work process followed by social workers in the health care team. The aim, therefore, involved increasing access and referrals to undergo specialist consultations and tests and qualified care for users through health education technology, in order to ensure the provision of information about the health and disease process and attainment of social rights.

The UFJF Residency Program in Family Health (RESF) began in 2002 on the back of a partnership between the UFJF Centre of Consultancy, Training and Education in Health (NATES) and the then Juiz de Fora municipal Secretary of Health, Sanitation and Environmental Development (SSSSDA/PJF). As a proposal for service-learning integration, the RESF upholds the purpose of training human resources through work experience for the Unified Health System (SUS) and, above all, for Primary Care, based on the local reality. It has also represented a rich space for reflection, production of knowledge and qualification of health care.

In 2010, the Multiprofessional Residency Program in Adult Health was implemented, closely following the Residency Program in Family Health model, and was added to the set of Residencies in Clinical Analyses, Physiotherapy, Pharmacy, Nutrition, Physical Education, Psychology and Social Work. This young initiative adds to the others in the sense of promoting collective and interdisciplinary work qualification, as by numerically increasing the range of the Health Residency program, this considers the historical interest in relating the thirteen professions that form the health care field, as foreseen in the guidelines issued by the National Health Council in 1997.

The two UFJF Residency programs are funded by scholarship grants. The first, the Hospital Residency in Social Work, is maintained by UFJF funds; and the other two modalities, Multiprofessional Residency in Family Health and Multiprofessional Residency in Adult Health, are funded by the Ministry of Education (MEC). Both programs have complete work and remuneration equality, just as is practiced by the traditional medical residency model. These programs develop their teaching and care experiences at complex levels of the health system, serving each one specifically, as per the SUS guidelines and in accordance with the Social Work parameters for the health care area. The residency is a full-time (60 hours per week) program that lasts 2 (two) years, corresponding to 5,760 hours of work.

The Hospital Residency in Social Work develops service-learning integration in the HU/CAS – Santa Catarina and Dom Bosco Units - through individual and group works on the wards and special outpatient facilities, combining these efforts with primary health care.

The training of multiprofessional residents in Family Health takes place through their direct participation in Family Health team at two Municipal Health Units of Juiz de Fora (Parque Guarani and Progresso). The Multiprofessional Residency in Adult Health is also developed in the municipality, at the Santa Cecilia Health Unit, through programmed contact at the secondary and tertiary care levels and also through the Specialization Course in Collective Health Research and Policies, that considers the two modalities of Hospital and Multiprofessional Residency in Family and Adult Health. The latter, Multiprofessional Residency in Adult Health, that involves activities similar to those developed by the
Family Health Residency, will not be considered in this article, due to the short time since its implementation (8 months).

Following the description of the existing programs, the conceptual bases of the ethical-political and pedagogical project that support the residencies work shall be presented. Three founding and guiding principles for the Residency Programs in Social Health shall be focused on, which have already been introduced in this work: service-learning integration, related technology aimed at care production and the integration of other UFJF courses.

CONCEPTUAL-THEORETICAL BASES OF UFJF SOCIAL WORK RESIDENCIES

service-learning integration

The following statements are supported by the theoretical discussions of Ceccim and Feuerwerker and Albuquerque et al, that address the importance of permanent education in health and of service-learning integration, and whose orientations have guided the Residency Programs in Social Work, built over the years between 1998 and 2010. These discussions have become to conceptual and operational basis both in the HU/CAS space and in the basic health units, providing the main contributions to relations between learning and assistance by recognising that a space for intersection between service and learning is essential for the formation and consolidation of the SUS.

These discussions are based on the SUS values and the Code of Ethics for Social Workers. Internal to the debate and also evident in indicators are conflicts, difficulties, strategies and tactics that have unfolded for occupation in the care network, that upon implementation require accurate stewardship in order to ensure that the proposed principles are followed for this special kind of training developed in a simultaneous work and learning process.

Therefore, according to Albuquerque et al, constant interaction between theory and practice is sought, leading to critical review that becomes a requirement for the practice, without which the theory could be construed as a fallacy, and the practice as mere activism. The service-learning integration effectively occurs upon the uniting of teachers, residents and professionals from the various health care fields, focused mainly on the user in order to minimize the dichotomy between teaching and health care production.

The current intention is to reverse the direction of implemented user care, alternating, as per necessary, the costly flexnerian health care procedures of medical specialties, burdened by excessive medicalization, with related technologies centred on receptive attitudes and on the relationship with the user. Therefore, the idea is to practice care through prevention rather than cure, with the ultimate purpose of health work based on protecting lives and citizens’ rights. In this sense the construction of disease control and health promotion actions and strategies, of continuous training and qualification, of education and communication in health, of comprehensive care, private-public sector interaction and equality becomes a part of the agendas and approaches for intervention of health care teachers, residents and professionals.

In this context, it is worth highlighting the role of the resident in health care. Whereas on the one hand social, economic and political factors determine to a great extent the structure and organization of the services, as regards macropolitical aspects; on the other, the care profile and functioning are given by micropolitical processes and the technological configurations of the work, through which health care production effectively takes place. It is therefore impossible to disassociate the proposed change to the technonassistential model suggested by the SUS from the changes in the training of health professionals. In this regard, service-learning integration becomes a privileged space for reflection on learning and care production.

The aforementioned authors observe important aspects in the dialectics of learning, directed at a user-centred model that is gradually transformed into the presence of new technological arrangements, sustained by the relationships among individual workers and between them and the users. It is often the autonomy of the health professional that determines the profile of the technical care model. Their freedom of action proposes changes capable of cooling the traditional health service organization processes. That is why any change in the care model requires, to a large extent, the construction of a new consciousness regarding sanitation and education and the adhesion of these professionals to a new
project that constantly adapts to reviews made of the procedures.

It is always important to achieve a consensus regarding the forms of work in line with the new care proposal, which is not possible through vertically established standards. Hence the emphasis on the permanent education process, grounded on the service-learning process, that invests in knowledge development aimed at user protection and the user’s right to health care. This rests on the technological relations established through service-learning and aimed at health care production.

Service-learning integration, based on teamwork developed in residency programs, should be conceived bearing in mind both the development of collective and interdisciplinary competences and the strengthening of specific skills of each profession. Every residency educational process is built around the conception that the resident is capable of developing work together with professionals from other health care fields, focusing on interdisciplinary work to compose health care shifted from the corporate axis, cropped and reduced, to the plural, complex and user-centred axis.

For Ceccim and Feurweker, the intertwining movement within the cross-functional health team would, through the therapeutic resources and instruments of each body of knowledge and actions of each professional, offer the opportunity to form and construct collective intervention, consisting of each individual performance amplified or modified within a team-protected performance, with the goal of treatment projects responsible for providing solutions through health services and actions.

The proposal for permanent education arises from a central challenge, consistent with the intentions of service-learning integration, close to the heart of health care residencies. Learning should take place in a decentralized, ascending and interdisciplinary manner, in other words, at all sites, involving the whole set of knowledge available and developed through everyday interaction in health services. This is expected to result in more democratic work spaces, the development of learning and teaching skills of all actors involved, the search for creative solutions for problems encountered, the development of group and matrix teamwork, permanent improvement of the quality of health care and humanization of the service.

The concept of permanent education in health, adopted by the UFJF health care residency programs, notably for social work, offers the central proposal of establishing a close relationship between education, management, care and participation in this specific field of knowledge and practices, through the intercessions promoted by the health care education methodology (education intercedes in health care, renewing its learning technologies) and by interdisciplinary and cross-sectorial training (the alliance between fields of knowledge and the combined modes of intervention of public policies).

relational technologies and care production

The UFJF social work residencies, ever since the creation of their specific projects, have involved the implementation of relational technologies in the production of health care. Authors such as Merhy, Franco and Ayres have added contributions to the construction and implementation of these continuous training processes, offered in specialization courses, study groups for disciplinary integration and analysis of everyday experiences.

It should be stressed that relational technologies have always played an active part social work practices, regardless of the different names assigned to the profession over the course of its development. They have always belonged to the compositional design of the social service (theoretical foundations, principles, ethical guidelines, policies and methodologies and interventional understandings). They therefore represent an immediate support arm for intervention, according to the requirements of the specific field of work, as exemplified by health care in this text.

The relational technologies based on respect for human dignity, for different values and cultures, for denying any form of discrimination and prejudice and on people’s right to receive all the information about their social status, over the course of time incorporate other indispensable principles, such as: the defence of democracy in general, of social participation and guaranteed citizenship in terms of civil, political and social rights, and of a commitment to maintaining a high standard of public services. These foundations, underlying the relational technology operated by the Social Service, are transposed to the health care field and establish the work
performed by social workers/residents and are continuously reviewed by supervision and monitored by tutors and preceptors of the practice in all three complexity levels of the health system.

Social workers, as professionals committed to providing care, are trained to build relationships with the user, making use of technological options, such as: teamwork, care production/assistance management, home visits and group work, which create a bond and a sense of responsibility in the user. Inherent to this is the knowledge that the act of caring is central to health work. By means of care production it is possible to attain health, which is indeed the desired objective, whether through individual or collective care, executed with user groups.

The singular therapeutic project, which involves relational and therapeutic technologies, is aimed at analysing health services as a space for understanding user flows, demands and needs by means of shared work. The aim is to compose a horizontal care model capable of absorbing the integrated health networks, relativizing the concept of hierarchical services, and forming teams receptive to user demands and needs.

The conception of health work that underlies social work residencies is expressed beyond traditional technological skills. Residency programs use the concept of light or relational technologies of the type that produce bonds, autonomy, reception, management, special and alternative forms of reinforcing the work processes, centred on the user’s right to access to quality services.

The relational technologies usually developed by the Social Service in the various levels of complexity of the health system are: Education in Health or Emancipatory Education, Planning and Management, Teamwork, Collective Work, Information and Communication, Reception and Bonding Practices, Home Visits. All these are directly implied in the execution of research projects and updated in the acquisition of new learning from continuous social work studies.

Information technology and communication, teamwork, home visits, production of progressive care lines in the integrated health networks and horizontal, democratic management are all cultivated, to the highest standard, by the specific formation of the UFJF social work residencies, that involve the main instruments of intervention in their language and line of development.

**social work residencies integrated into other UFJF courses**

In 1988, through the FSS/UFJF, the University Hospital Collective Health Program was implemented. The intention was to combine social work hospital residency with a 360-hour specialization course. The aim was, and still is, to offer residents the opportunity to add investigative and theoretical reflection in the field of health care, the social service and collective work to their professional experience.

This project represented an unparalleled example of contribution toward human resource training that UFJF was able to bring to the sphere of Brazilian Federal Universities by defending a training project centred on interdisciplinary and complementary health work processes. The Specialization Course is currently the basis for hospital residency programs in: social work, psychology, nursing and clinical analyses and multiprofessional residencies in Family Health and Adult Health, and also involves the courses in Management, Economics, Physical Education, Physiotherapy and Nutrition.

Moreover, the residencies reinforce the training that takes places in the space devoted to undergraduate internships, when students from different professional disciplines share with residents the social work and health practices in the wards and outpatient clinics, participating in thematic discussions regarding the social service and health policy and adding depth to the embryonic elements of the collective work process.

Twelve years since the implementation of the social work residency program and specialization course, gaps can still be found in terms of interdisciplinary training. Some professions tend to remain somewhat guarded behind closed doors, preserving their specific expertise and work methods. In these cases, it is fairly common to observe attempts to reinforce corporate stances or shield themselves behind their respective codes of ethics when they are unwilling to share information, want to maintain the power relations in place or even ensure that management of the health care institutions remains exclusively in the hands of the medical profession, which is historically considered the natural leadership in the health care environment.

Sharing everyday routines in the same work space combined with attending the same specialization course
gradually started to minimize the differences embedded during undergraduate study. Now, such singularities are beginning to be reviewed through the MEC policy, aimed at achieving comprehensive training, as can be seen in the multiprofessional residency programs. The first of these was created in 2002 and has been assessed in positive light by several published studies and dissertations that portray the everyday work routine of the Family Health Strategy. The second, recently created, Multiprofessional Adult Health Residency, which is currently under its first review, has already proven its worth despite the lack of facilities and human resources typical of the current municipal health management of Juiz de Fora.

In order to resolve the myriad health problems, integrated and collective discussions and reviews are needed, allowing the problems inherent to the development of the different disciplines to be tackled, and creating an adequate space for building therapeutic projects. The groups, working in hospital wards and outpatient clinics, are now strong components of the hospital residency and are partly coordinated by the Social Service or by social workers belonging to the work teams. In order to transform the relations with users and other health professionals, there is nothing better than joint review from a multi-focused and consolidated perspective through the implementation of thematic studies and research projects.

It becomes evident that only recognition of the thirteen health care professions by the National Health Council in 1997, although fundamental, is insufficient if no support is provided for an education policy and methodology that aim for integration of the specific knowledge sets of each of them.

The creation of the Specialization Course added to the HU/UFJF and the family and adult health multiprofessional residency programs is, without a doubt, an important space for enabling such integration, but requires reinforcement by service-learning integration methodologies that follow the proposed innovations resulting from the everyday practice of health services.

The specialization course aims to qualify health professionals with the ability to reflect on: the context of the practice, the adoption of a critical posture in relation to the work and knowledge acquired, the integration of different knowledge sets in health care action planning and focus on teamwork, and the exercise of working in an ethical manner, extending their dedication beyond cure and towards disease prevention and health promotion.

That is precisely why the overriding objective of this aggregating experience is to shape the teaching so that it is always aimed at ensuring understanding by the professionals of the needs presented by the health service user public.

**TRAINING SOCIAL WORKERS IN THE UFJF MULTIPROFESSIONAL RESIDENCY PROGRAM IN FAMILY HEALTH CARE**

The learning process is supported by strategies structured on interdependent and complementary “axes” that interact and translate the various residency training possibilities. These different “axes” include:

**theoretical-methodological reflections and discussions**

It is our understanding that in their everyday work, social workers require a theoretical-critical grounding for precise comprehension of the reality, revealing the contradictions that have emerged within society and in health policy.

Any qualified health care professional should have a reasonable understanding about health policy and its implications for the social service in order to make concrete mediations between professional demands and responses.

The distance between professional practice and theoretical content of the professional reality, resulting from a lack of critical interpretation of how the reality moves, reveals opportunities wasted by social workers and other health professionals in relation to the different practice possibilities that could be captured in the reality in which they perform their actions, in redirecting public policies toward user interests. (p. 254)

Drawing on this understanding, discussion spaces are set up so as to ensure constant communication and exchange of experiences and theoretical-methodological reflections between academic and service experts and
residents. The following activities are organised under such an approach: a) Monthly meetings for residents and preceptors – these meetings address issues relative to the functioning of the residency program, defining social work actions, exchanging work experiences developed at health units, review of the inclusion of social work in the residency program and the activities developed by social work residents; b) Study Group (General) - the study group is also a monthly activity. This group brings together all the residents and preceptors, constituting an important space for theoretical thoughts and exchange of knowledge. The discussion topics are defined together with the residents, in accordance with the needs they feel for deeper theoretical understanding; c) Study Groups (Per Health Unit) - study groups are held at the units at two different times. There is a group of teams that discusses cases seen in the units and another that brings together all the social workers for a discussion regarding the topics defined according to the needs of the service; d) Participation in Congresses and Seminars – residents and preceptors are encouraged to participate in such events, as an excellent way of staying up-to-date. In these events, we also seek to present works relative to the activities produced in the family health residency program (RESF).

The activities proposed on this axis are aimed at professional qualification and updating, since a social worker’s activity is directly linked to the social reality and movement of society. This concern is manifest in the sense of “ensuring” a fundamental principle of the Code of Professional Ethics which is to guarantee service quality for the public.

assistance to users and families

In the assistance for users and their families, we draw on the understanding that these people hold rights and should be cared for based on the principles of the SUS. The objective of the work performed in APS is to socialize information and ensure the fulfilment of rights, seeking to contribute to the collective distribution of demands, service access, public participation, granting users autonomy to cope with their lives, in short, the practical application of the principles of the SUS and the PSF.

Residents participate in different actions in the health units. These include: individual and collective care for users and families; referrals of users and families to social assistance resources; advice on rights and social and welfare benefits; home visits; planning and participation in arranged groups - pregnant women, SAD (Home Care Service), Reproductive Rights, among others.

During the assistance services, the social worker attempts to identify the user’s family background, welfare and employment situation, housing conditions, basic sanitation and knowledge of the health-disease process, any barriers to accessing treatment and care options.

Based on this review, individual and group advice is given, including clarifications and referrals for insertion in social programs and benefits such as the basic food basket, family allowance, social security benefits, social care and other user rights, and referrals to the health and social care network; advice regarding mental health and relationships with family members and the wider community.

Iamamoto\(^2\) (p.176) points out that in their professional exercise, social workers intervene in everyday relationships, expressed by the manifestations of social issues and “experienced by social individuals at work, in the family, in the struggle for housing and land, in health, public social welfare, etc”.

Buss\(^8\) shows that the main health problem in Brazil is unequal health and social conditions, and difficulties in overcoming these obstacles. Therefore, the health service clearly requires the insertion of a professional whose training has been focused on the living conditions of the public and the formulation of social policies.

participation and social control

From the perspective of social control and participation, the residents participate in the University Extension Project “Health Promotion: Shared Construction”, the main objective of which has as main objective is to develop actions that strengthen community participation and their capacity to make effective interventions.

The project arose from the need to expand Social Service intervention and create new alternatives and possibilities of resident training. It emerged, therefore, through the Social Service’s commitment to increasing community participation in defence of their health and quality of life and to the training process of the residents.

We understand that this experience of university extension has represented a rich training ground for
residents and an effort by UFJF to expand beyond its boundaries. According to Iamamoto9 “the extension consolidates and broadens the political dimension of the university - at the service of the community - democratizing it and reverting its activities in an effort in the public sphere.”

In addition to participating in the Extension Project, the residents partake in the Local Health Councils (CLS) advising the Councillors in their struggle to ensure their communities the right to health care.

We can also highlight their role in Health Councillor Training Projects. We note that such projects entail a level of concern regarding the safeguarding of democratically available information, working towards contributing to the “users appropriating categories of intellectual property analysis, so that they can, as far as possible, place themselves critically before their everyday experience and participate in the political struggle to defend their interests”10.

The intervention process through the Councils is of utmost importance, as the Health Council represents a stage for struggles between conflicting interests, which express different societal projects and different directions for health policy. And “the segment that represents the subordinate classes could intervene so as to avoid the commercialization of public funds”11(p. 127), helping to ensure that the resources are spent on caring for the public’s real needs and “are not placed at the mercy of elitist, private interests and/or “electoral herds”11 (p.135). Mioto and Nogueira12 add that platforms for community participation are essential to the process of public sphere construction.

surveys and research into socioeconomic and sanitary conditions

We understand that access to data about the economic, political, social and cultural conditions of users is essential when working with the concept of health as a result of living conditions. We believe these data are important for the identification and analysis of the factors involved in the health/disease process of users, at both an individual and collective level.

In this light, we have encouraged residents to incorporate this activity into their daily work. Among the various surveys conducted, we highlight three, either on account of being experiences of team work between Health Units, or for being associated to the University Extension Project: a) Participatory Social Diagnosis; b) Survey of Community Social Resources; c) Children and Teenager Profiling.

We have also encouraged the residents to participate in Research Groups of the School of Social Work. Residents are currently beginning to participate in the research study entitled “(Re)building Primary Health Care in Juiz de Fora/MG: accounts by managers and users of public health services”.

production of technical material

The residents have invested in the production of workshops for training Health Councillors for the University Extension Project, as well as for the existing operative groups in the units. The development process of these workshops has represented a special moment, for it is a chance to test the residents’ capacity in terms of theoretical reflection and creative capacity to propose work methodologies that transform the meetings with users into platforms for discussion and debate.

planning and work organization

Vasconcelos13 notes that the definition of professional projects and the possibilities of attending to demands should be attributed to the social work professional. That professional should be responsible for creating the services to be offered, based on the institutional movement and demand by its users. The work should not be centred on attending spontaneous demands, but, to the greatest degree possible, on collective strategies.

It is the social workers, due to their professional training and the position they occupy, who are able to critically evaluate the wealth of data and information that accumulates and/or can accumulate about institutions, segments of the public and the everyday routine of their practice. They are permitted access to files, to all kinds of documentation, data resources, research projects [...], and can create time, space, routines,
different activities, aiming at a quality practice. They are responsible for conducting surveys, research, producing knowledge about the institutional movement, about the service itself, about the data relative to assistance given to users [...], explaining the trends in the social reality addressed, they can take a critical stance and define priorities, strategies, alliances, limits and possibilities, evaluating the consequences of the actions taken\(^\text{13}\). (p. 144, our translation)

Residents actively participate in the whole planning process of the working teams. To this end, general meetings and team meetings are held weekly with all professionals, in addition to the meetings split by category. The general meeting addresses administrative matters, whereas the team meetings discuss specific cases, ACS demands and planning. In addition to the general and team planning, the residents also participate in the specific social work planning.

**education in health care**

We understand that Education in Health Care occupies a privileged space in social worker intervention and as such, permeates all the professional’s actions. It is from this standpoint of demarcating this “place” of Education in Health Care that we attempt to train residents. We reinforce that, in the APS, education in health care is a special feature of Social Work, as the professional understands the health/disease process based on a reflective outlook of the relations between psychological, cultural and socioeconomic factors. Referring to participatory techniques, he understands education in health and access to information as a right.

According to Assis\(^\text{14}\), education in health care goes beyond a process of transferring information, as it entails the training of individuals and groups to transform the reality into which they are inserted. This perspective draws on the critical capacity to question the vertical transmission of knowledge and information, valuing popular knowledge through a relationship of exchange and dialogue that produces redevelopments, closer relations and learning between professionals and users.

**HOSPITAL RESIDENCY IN SOCIAL WORK: TWELVE YEARS OF EXPERIENCE IN HEALTH EDUCATION**

**background**

The Residency Program in Social Work, approved in 1997, aims to: train social workers at *latu-sensu* graduate level, with a view to continuous education and knowledge relative to health; contribute to the integration of professionals within an interdisciplinary, complementary perspective between social and biological knowledge; deepen their knowledge of teaching practices; stimulate research; plan, implement, intervene in and evaluate care programs in the areas of the university hospital; expand knowledge in health, train professionals to generate knowledge and provide benchmark assistance in the teaching hospital.

The residency is the learning space in which social work, while grounded on knowledge predominantly in health care, also presents to professionals of the field concepts from social and political understanding in relation to health. Therefore, it mediates two branches of knowledge that, as well as producing a mutual benefit, directly contribute to qualifying the assistance in the services, with direct answers to the population’s needs\(^\text{15}\)(p.61).

This program intends to establish a paradigm that overcomes the poles of public health/individual medical care, or prevention and cure, to achieve a new quality of care, so that the population is able to understand the meaning of the right to health care and the proportions of the social inequalities. To this end, public representations about health, disease, health services, quality and the availability of professionals should be valued\(^\text{15}\).

Social work, as a discipline belonging to health work, has in its residency programs the greatest opportunity to broaden its own training - assimilating knowledge and practices relative to health care - and contributing with actions that require strengthening of the education and assistance process in the most diverse expressions of health and disease\(^\text{15}\). (p.58)

In the 1990s, the HU/UFJF social work made a jump in quality resulting from the consequences of discussions
held in the 1980s, with the establishment of the LOS, LOAS and the start-up of SUS operations, and the transformations of the profession that reviewed its objectives and defended the issue of a new Professional Code of Ethics, which, among its main guiding principles, prioritizes freedom, the defence of human rights, strengthening of citizenship, defence of democracy, equality, social justice and a commitment to quality services for the public.

conception of hospital residency in health

The residency should encompass two moments (teaching and care) where one sustains the other, removing the exclusiveness of the work performed especially in the care, which sees the residents charged primarily with maintaining the care routine at the university hospital, as still occurs in the medical residency.

The education part remains the responsibility of the teacher/tutor, who guides theoretical discussions based on the work process, supported by the essential work of the professionals/preceptors, responsible for the knowledge provided through hands-on experience in everyday practice of health services. The teacher/tutor and the professional/preceptor are available to provide guidance on intervention projects, research and extension studies, helping include the residents in the theoretical and practical production process.

Residency in social work emerged bound to the concept of Public Health Reform, with emphasis on the following principles: social control, comprehensiveness, universality, equality, decentralization and regionalization. Furthermore, it assumes as a condition for its performance, work supported by guidelines that aim to change the organization of health services based on reception, humanization and relations, core elements that support the work process steps performed in the university hospital.

structure and organization of the work process

The purpose of social worker’s activities with users of the HU/UFJF is to enable these people access to public policies and/or community resources, working based on the expanded concept of health, that comprehends health as conditioned to social factors: eating habits, housing, basic sanitation, income, education, and others.

The services performed by the social work team should be based on the logic of social rights, reinforcing notions of citizenship, right to health and other social policies in relation to the users. The education in health process is seen as essential to grasping this logic, as well as to disease prevention and health promotion.

Social work in HU/UFJF is organized into work in the hospital units, outpatient work and duty shifts. In the units, this work is performed through insertion of the social worker/resident in surgical units, paediatric wards, female care and gynaecology units, male care units and intensive care units (ICUs).

To perform the services, the professionals first review the patient’s records to gather information about the patient’s medical, social and family background and then make bedside social engagement. This approach is made using information gathered from the patient’s records and addresses issues related to their welfare situation, employment, family, access to health services, understanding of the health/disease process, to then provide guidance and necessary referrals based on the demand presented.

The most common demands on the wards are: advice and arrangements related to hospital admission; essential documents; contact with family members to reinforce the treatment; arrangements in relation to patient companions (contact with relatives); welfare/assistance advice: welfare sickness allowance, retirement through permanent disability; continuous support benefit for disabled and/or elderly/BPS-LOAS; guidance about sick notices; guidance about public transport concession schemes; request for transport for patient support; contact with institutions about availability of orthoses and prostheses; domestic violence; negligence in relation to elderly and children; contact with institutions about inclusion in a program or service; advice about governmental programs; accompanying hospitalized patients for bone marrow transplant, at the male care unit (exclusive beds) and decisions about medical examination reports by the National Social Security Institute (INSS), and other matters that arise.

The social worker assigned to the wards is also responsible for coordinating a group of users according to the specific characteristics of each hospital unit. These
projects are developed based on education in health, encouraging a continued exchange of experiences between group members and the team. In the Male/Female Surgical Unit, the University Project “Surgical Moment: a perspective of interdisciplinary work” is conducted with the participation of social workers, nurses and psychologists.

In the paediatric unit, there is the professional training project “Comprehensive Accompaniment of the Families of Children Hospitalized in the University Hospital Paediatric Unit”, with a team composed of social workers, nurses, psychologists, dentists, physicians and artists. Also implemented is the Extension Project: “Interdisciplinary Ostomy Care Aimed at Rehabilitation – HU/UFJF”. In the Women’s Medical Unit, the Extension Project is entitled “Speak Woman” and has a team of social workers, psychologists and nurses, and the Extension Project in the Men’s Medical Unit is “STDs/AIDS: aiming at prevention”.

In the outpatient activities, the social workers/residents are inserted in specific outpatient services, in extension projects or professional training schemes, and in on demand services. The specific outpatient services are for Paediatric Nephrology, Cystic Fibrosis, Parasitic Infectious Diseases (PID) and Pneumology. The Extension Projects are: “Chest Out Project: Breast Cancer Prevention and Integrated Accompaniment Program”; “Live Better: Comprehensive Care for Women in the Menopause”; “Interdisciplinary Care for Leprosy Patients: A Health Education Proposal”; and “Monitoring, Education and Prevention in Diabetes Mellitus”. The projects “Prevention and Treatment of Smoking – Tobacco Free UH Program” and “Flourish – High-Risk Newborns” are professional training schemes. Some of these projects also include waiting room service, as well as individual and group service.

The duty social worker’s job is to receive the health service user at the hospital, inform him/her about how the hospital works, its rules and routines, introduce the social service to the user, guide family members when visiting users and offer instruments to the user in order to ensure their rights.

All these activities are accompanied by the execution of supervision of interns and/or scholarship students and discussed with the HU/CAS preceptors, at the weekly intern supervision at FSS/UFJF; and the most complex situations and theoretical-practical studies are reviewed and discussed in the weekly guidance meetings with the tutor and coordinator of the Social Work Residency Program.

hospital residency in social work and technologies related to assistance/health care production

Today there is great emphasis on the use of health care technologies. These technologies have always been part of the arsenal used in social work, which, through the process of building relations, aims at the defence of human dignity and social rights and respect for differences, which values underlie the profession. All these contributions correspond to sustaining relational technologies used in the everyday business of a teaching hospital, experiences under construction, with the concrete aim of achieving quality management (organization of work process and resources) and quality assistance (care production) that simultaneously present difficulties and solutions experienced by the social workers/residents. The most significant of these technologies are:

assistance/health care production management

Assistance/health care production management is a dynamic process developed by social workers/residents at the teaching hospital, following agreements made between the macro and micropolitical spheres, guided by the SUS foundations and based on organizational practices and knowledge to strictly defend the interests and needs of users. The intention is to retrieve, through the social workers’ activities, the precepts of the Public Health Reform so as to ensure comprehensive access to assistance/production of health care services.

democratic service management

The social workers/residents observe and reflect on the management by the General Directorate and the Social Service Management of the HU/CAS, in order to understand the political and administrative agreements and their referrals within the teaching hospitals and reinforce learning about the principal conceptual and operational
elements of public management. The residents reflect on the activities of the health professionals in the work process based on priorities defined in the contracting process, with clear reflections on the administration of assistance between the HU/CAS and SMS/JF managers. This approach of bringing together the educational, care and organizational aspects of the teaching hospital helps one identify the importance of the cooperation and the construction of management based on democratic principles, and simultaneously prepares professionals to understand the relation between micro and macro politics within the hospital.

**teamwork and collective work**

Team work is a horizontal process of sharing theoretical and practical knowledge. This features mutual relations and complementary concepts and disciplinary practices, in the sense of establishing the efforts required for health service educational practices. This concept of teamwork is based on interdisciplinary exchange, communicating ideas, integrating concepts and constructing objects of new investigation and interventions in partnerships, so as to dilute, in practice, the vertical and still hegemonic corporate conceptions.

**information and communication**

Information and communication planning sustained by the social workers/residents inside the teaching hospital is supported on this statement: The user has the right to receive all the information about his state of health. Grounded on the construction of communication bases between all the hospital sectors, using the methods and alternatives that enable the creation of extended communication flows and the negotiation of new and old commitments in order to ensure the users’ rights. The information, according to Merhy is a tool that enables continuous review of this game of the apparently functional and non-functional, of the public and private, outlining from which ethical-political point one can judge the meanings acquired by the service and at which interests it is explicitly directed. As a tool of analysis, information can reveal the noises that the instituting forces cause in the everyday work, enabling one to question the functional meanings of the service, the distant forms of interest games and the alternatives in place in the everyday workings of the health services.

**FINAL CONSIDERATIONS**

In this article we presented the main actions that outline the educational stage for residents. Through direct monitoring of the academic tutors and preceptors of the residents’ actions we are slowly but surely building the residencies. A residency committed to professional training and a universal, equal and high quality SUS.

In these final considerations, the first element to be highlighted is the relationship between learning and the service. The educational institutions are responsible for training human resources from a general education perspective, that understands the user as a subject, and not as a reproducer of instructions and prescriptions, with the overall objective of quality in the SUS. The closer relations with the University increase the professionals’ access to events, courses, seminars promoted by the institution or externally, as well as providing spaces for meeting and reflecting.

As regards assistance actions, we can highlight the need to overcome the immediate aspect and strengthen continuous actions that aim at putting the expanded concept into effect, for instance, through implementing health education actions. Beyond immediate actions, the long-term actions enable the strengthening of educational processes and training of the population for citizen insertion into public services, contributing to social control and the preservation and expansion of rights.

We can also highlight that the social worker should strive to develop actions qualified and supported by the understanding that her work should be guided by the approach to engage manifestations of a social nature that interfere in the health-disease process through acts aimed at producing a care based on the user’s needs.

We consider that social work in the residency programs has represented an unparalleled opportunity for professional development. The platforms provided – meetings, study groups, workshops, seminars, etc. - all represent to the residents, tutors and preceptors a wealth of learning opportunities, socialization of information, exchange of experiences, maturing and the construction of new practices and knowledge.
The Social Work Residency Programs at UFJF constitute innovative experiences, as they establish links between the services and the three levels of health service complexity, incorporate an interdisciplinary matrix from the outset, have the theoretical grounding of a 360-hour specialization course common to all residencies and combine SUS principles with the principles of the social work code of ethics.

REFERENCES

6. Vasconcelos AM et al. Profissões de saúde, ética profissional e seguri-
7. Iamamoto MV. As dimensões ético - políticas e teórico – metodoló-
9. Iamamoto M. O Serviço Social na contemporaneidade: trabalho e for-

CORRESPONDING AUTHOR

Auta Iselina Stephan Souza
Rua Ivan de Oliveira, 50
Parque Imperial - Juiz de Fora
CEP. 36036-350 MG
E-mail: stephan.souza@yahoo.com.br