Revista Científica Escola de Saúde Pública do Ceará Paulo Marcelo Martins Rodrigues
1808-7329 (1809-0893)

EXPERIENCE REPORT, UPDATE AND/OR TECNOLOGIC INNOVATION
Public / Collective Health

SOCIAL SERVICE CONTRIBUTIONS IN HEALTH EDUCATION ACTIONS

CONTRIBUIÇÕES DO SERVIÇO SOCIAL EM AÇÕES DE EDUCAÇÃO EM SAÚDE

CONTRIBUCIONES DEL SERVICIO SOCIAL EN LAS ACCIONES DE EDUCACIÓN DE SALUD

Maria Andreia Lima Silva[1], *Roberta Duarte Maia Barakat*[2]

ABSTRACT
Objective: To analyze the contributions of Social Services to health education actions, highlighting the relevance of these activities in Primary Health Care (PHC). **Methods:** This qualitative and descriptive experience report was based on interventions in the waiting rooms of the Catarina Evangelista de Sousa UAPS in Icapuí, Ceará, Brazil. Data were collected through field diaries, documenting reports, experiences and perceptions of clients and professionals. **Results:** Four waiting rooms were created with themes aligned with the calendar of public campaigns. The activities promoted reflection on social rights and health prevention, generating a stronger bond between clients and professionals. **Final considerations:** The experience highlighted the relevance of Social Services in health education, promoting user autonomy and contributing to constructing a more equitable and humanized SUS.
Keywords: *Health Education, Social Work, Primary Health Care.*

RESUMO
Objetivo: Analisar as contribuições do Serviço Social em ações de educação em saúde, destacando a relevância dessas atividades na Atenção Primária à Saúde (APS). **Métodos:** Trata-se de um relato de experiência qualitativo e descritivo, baseado em intervenções realizadas nas salas de espera da UAPS Catarina Evangelista de Sousa em Icapuí, Ceará. Os dados foram coletados por meio de diários de campo, documentando relatos, experiências e percepções dos usuários e profissionais. **Resultados:** Realizaram-se quatro salas de espera com temáticas alinhadas ao calendário das campanhas públicas. As atividades promoveram uma reflexão sobre direitos sociais e prevenção em saúde, fortalecendo o vínculo entre usuários e profissionais. **Considerações finais:** A experiência evidenciou a relevância do Serviço Social na educação em saúde, promovendo a autonomia dos usuários e contribuindo para a construção de um SUS mais equitativo e humanizado.
Descritores: *Educação em Saúde; Serviço Social; Atenção Primária à Saúde.*

RESUMEN
Objetivo: Analizar las contribuciones de los Servicios Sociales a las acciones de educación de salud, destacando la relevancia de estas actividades en la Atención Primaria de Salud (APS). **Métodos:** Este relato de experiencia, descriptivo y cualitativo, se basó en intervenciones en las salas de espera de la UAPS Catarina Evangelista de Sousa en Icapuí, Ceará, Brasil. Los datos se recolectaron por medio de diarios de campo, relatos documentados, experiencias y percepciones de usuarios y profesionales. **Resultados:** Se crearon cuatro salas de espera con temas alineados al calendario de campañas públicas. Las actividades promovieron la reflexión sobre los derechos sociales y la prevención en salud, generando un vínculo más fuerte entre usuarios y profesionales. **Consideraciones finales:** La experiencia destacó la relevancia de los Servicios Sociales en la educación de salud, promoviendo la autonomía de los usuarios y contribuyendo a la construcción de un SUS más equitativo y humanizado.
Descriptores: *Educación en Salud; Servicio social; Atención Primaria de Salud.*

INTRODUCTION

The National Primary Care Policy (PNAB) ensures universal and comprehensive access to health, and primary care is the main gateway to the Unified Health System (SUS). This model strengthens prevention, promotion, treatment, and rehabilitation,

[1] Escola de Saúde Pública do Ceará. Fortaleza/CE - Brasil.
[2] Universidade Estadual do Ceará. Fortaleza/CE - Brasil.

focusing on family and community health through multidisciplinary teams and integrated care strategies[1].

In this setting, health education is presented as a continuous, dialogical, and participatory practice fundamental to stimulating the autonomy of subjects and communities in building knowledge, attitudes, and practices to promote healthy life. Beyond transmitting information, it encourages critical reflections on the Social Determinants of Health (SDH), health rights, and shared responsibility in care[2].

By breaking with the market-based and exclusionary logic, health education follows the Health Reform principles and understands health from a comprehensive perspective, not just as the absence of disease. This relationship has significant implications for developing the skills of health professionals and defining their role as ethical-political subjects in producing care. This dynamic impacts materially and subjectively the lives of clients, whether individuals or groups, through light technologies.

Health soft technologies refer to practices prioritizing communication and interpersonal relationships in healthcare, unlike hard, medical equipment-based technologies. These approaches are essential to streamline the interaction between health professionals and patients, promoting self-sufficiency and effective care. The interdependence between health education and health work is essential, as both influence the ethical-political formation and the leadership of the subjects involved[3].

In this context, Social Services have been working to date back to social struggles since the 1970s, when the Health Reform introduced a new model of thinking about public health, promoting health awareness to guarantee social rights[4]. Aligned with this reflection, the social workers' activity stands out for its socio-educational nature, in which professionals exceed the provision of services, developing educational actions that promote access to social rights and the full exercise of citizenship[5]. Their practice transcends individual care and strengthens the autonomy of individuals and their leadership in the SUS and society.

The research on this topic stems from the need to recognize and value health education as a fundamental strategy in Primary Health Care (PHC). This practice aims to transform the relationship between clients and the SUS, fostering their autonomy and active participation. This experience report arises from the daily experience as a resident social worker in Family and Community Health. Some main activities include advising on social rights and clarifying social assistance benefits, highlighting how health education manifests itself concretely in PHC.

From this context, this experience report aims to analyze the inputs of Social Services in health education actions. We intend to expand the debate on the relevance of health education and its articulation with the guarantee of social rights and the strengthening of the SUS.

METHODS

This descriptive and qualitative experience report discusses the contributions of Social Services in health education actions through activities in the waiting rooms of the Catarina Evangelista de Sousa Primary Health Care Unit (UAPS) in Icapuí, Ceará, Brazil. The registered population of the referred UAPS is approximately 5,077 clients. However,

this study focused on clients who were waiting for care on the days when the waiting rooms were held. The Family and Community Health residents linked to the Ceará School of Public Health (ESP/CE) developed the actions as part of the practical activities of their daily professional routine.

This experience report did not require submission to the Research Ethics Committee, as established by Resolution N° 510 of April 7, 2016, which provides human research standards and guidelines. This classification reinforces the importance of systematizing experiences lived in daily practice, highlighting their contributions to health.

Qualitative research investigates the universe of meanings, interprets reality based on symbolic aspects in behaviors, ideas, and viewpoints, and extrapolates numerical and objective data[6]. In this way, it is ideal for understanding the waiting room dynamics and the relevance of Social Service interventions.

Educational interventions were performed in the UAPS waiting room, with the participation of a multidisciplinary team comprising resident professionals to develop this work: social worker, nutritionist, nurse, and psychologist. Each room was planned in a coordinated fashion to discuss topics relevant to the health and well-being of clients, stimulating dialogue and critical reflection.

The "waiting room" is a favorable space for informal educational activities, making good use of clients' time waiting at the health unit. When prepared with intention, it becomes a space for receiving, dialoguing, and strengthening bonds between professionals and the community. It differs from the "conversation circle", which, although adopting horizontal dialogue, is usually previously organized and with a defined target group and limited time.

The topics were discussed through discussion groups, group activities, and the distribution of explanatory leaflets, each lasting an average of 30 minutes. During the time spent in the waiting room, clients also clarified their doubts. They asked questions on several subjects, a valuable opportunity to bring popular knowledge closer to technical-scientific knowledge. The activities were organized as illustrated in Table 1.

Table 1 - Details of health education activities.

Month	Campaign theme		Professionals involved	Material used
April		Raising Awareness of Autism	Social Worker, Psychologist	Informative folders
May		Combating Sexual Abuse and Exploitation of Children and Adolescents	Social Worker, Nurse	Informative folders
June		Raising Awareness of Violence Against Older Adults	Social Worker, Nutritionist	Informative folders
August		Raising Awareness and Combating Violence Against Women	Social Worker, Psychologist	Informative folders

Source: Prepared by the author.

Data were collected through field diaries, where the reports, experiences, and perceptions of professionals and clients involved were documented. The diaries allowed us to identify the main challenges, results, and potential of the interventions developed, highlighting the positive impact of health education in PHC. This qualitative methodology stands out for investigating the universe of meanings, allowing the interpretation of the symbolic aspects in the participants' behaviors, ideas, and viewpoints[6].

By explicitly focusing on the Social Services contributions, the report values the role of this professional category in promoting health and health education strategies in PHC. It highlights the work coordinated with other professionals in the multidisciplinary team.

RESULTS

The waiting rooms were developed in partnership with other residents and have outgrown their initial one-off space nature. They have become environments for qualified listening, knowledge exchange, and community empowerment. Each meeting aimed to work on a monthly theme, following the order of the campaign calendar.

Blue April: Raising Awareness of Autism; Orange May: Combating Sexual Abuse and Exploitation of Children and Adolescents; Violet June: Raising Awareness of Violence Against Older Adults; and Lilac August: Raising Awareness and Combating Violence Against Women, totaling approximately 23 clients' participation. The campaigns were selected based on the analysis of the health calendar and the observation of the most recurring demands in the territory, also considering action feasibility with the available resources.

Following the public policy calendar, four waiting rooms were held in April, May, June, and August 2024. The themes aligned with health policies were central strategies for raising client awareness. These campaigns brought visibility to priority issues and were enriched by distributing informative materials and implementing educational actions, which engaged the population around relevant health promotion and prevention themes.

Given this context, we could observe how the Family and Community Health Residency provides residents with a practical experience that significantly strengthens the relationship with health education. This experience is structured and integrated into the residency program content. It enables a greater connection between residents and the community, strengthening educational actions and promoting a closer dialogue aligned with local health demands.

The activities emphasized prevention, sensitizing guaranteed rights and access to protection agencies, such as the Guardianship Council, Women's Attorney Office, and the Specialized Reference Center for Social Assistance (CREAS). Moreover, the importance of anonymous reporting through direct channels, such as *Disque 180 - Direitos Humanos*, was reinforced.

During this time, we realized that although many clients were not specifically familiar with the names of the campaigns, they had relevant information on the topic acquired through personal experiences, stories heard in the community, and examples

broadcast by the media, such as television and social networks. This exchange of experiences was crucial to enriching the debate and increasing collective awareness. Listening to popular knowledge strengthened the bond between professionals and clients. It valued local knowledge, often invisible in the traditional healthcare model.

The educational practices promoted during the waiting rooms reaffirmed health promotion in primary care, highlighting the positive impact of integrating theory and practice in PHC. This practice ensured the content was accessible, transparent, and directly applicable to the clients' realities. The social worker's professional role included identifying expressed demands, allowing appropriate referrals/guidance for the network, and strengthening intersectoral coordination with other services, such as education and social assistance.

DISCUSSION

The Brazilian health system is one of the most important achievements regarding public policies. It emerged from a mobilization led by health professionals, researchers, artists, and civil society, known as the Brazilian Health Reform. This movement resulted in the creation of the SUS as we know it today. Working with health education means reviving the SUS principles and guidelines, which establish the concept of expanded health, breaking the private/hospital-centric logic[7].

Given the abovementioned, the results achieved in this study showed the potential of waiting rooms as health education spaces, confirming their role as crucial tools for promoting knowledge and sensitizing clients. The activities integrated local knowledge and educational practices, favoring the articulation between theory and practice. The methodology used was based on discussion groups and educational materials. It facilitated horizontal interaction between professionals and clients, respecting popular knowledge and promoting the leadership of the subjects.

In developing its actions, understanding health education within comprehensiveness is vital. This principle enables the implementation of integrated preventive practices that contribute to significant transformations in clients' daily lives. This critical approach to health education promotes a collective construction of knowledge, resulting in mutual and significant changes[8].

From a comprehensive perspective, educational health actions aim to include public policies and create appropriate environments in health services, transcending the biomedical model focused on clinical and therapeutic interventions. These initiatives involve libertarian and transformative pedagogical approaches committed to promoting full citizenship, improving quality of life, and valuing human beings and existence[9].

However, the limitations observed, such as the lack of material resources and the difficulty in engaging participants, suggest that external factors, namely, the scarcity of materials and resistance to active participation, may compromise the effectiveness of educational actions. In addition, the low adherence of health professionals to interdisciplinary action was a significant obstacle, highlighting the need for greater integration between the different team members to strengthen the collective health approach.

In this sense, and as part of a dialectical process, we should highlight the

challenges observed in implementing waiting rooms. One of the main hurdles is related to the dynamics of these moments, in which impatient clients often struggle to stay focused on the proposed activities. Although the topics discussed arouse interest, it is common for some participants to shift their focus to the reception call screen, which limits interaction and engagement in the debate.

Furthermore, the low adherence of health unit professionals hindered interdisciplinary integration, a dimension for strengthening and expanding the impact of health education actions. These limitations stress the need for more structured and participatory strategies and strengthening teamwork to enhance educational practices in waiting rooms. Despite these difficulties, waiting rooms have enriched, promoting knowledge exchange between professionals and clients. Residents' active participation has allowed the planning and implementation of educational actions that value local knowledge and integrate public policies. This report reinforces the importance of health education as a tool for strengthening PHC and building quality public health. Furthermore, the positive impact of the articulation between theory and practice in the work of the social worker is highlighted, reaffirming the potential of waiting rooms as transformative spaces[10], which transcend the mere transmission of information and seek to promote clients' autonomy.

FINAL CONSIDERATIONS

The experience reported showed how health education actions can be consolidated as transformative tools in PHC by promoting dialogue between professionals and clients, valuing local knowledge, and integrating receptive practices. In this context, the waiting room was reinterpreted as an educational space and an environment for strengthening ties with the territory, contributing to the democratization of knowledge and the leadership of subjects. Given the abovementioned, social workers' activity was crucial due to the coordination between different subjects and their ability to identify social demands and promote awareness about rights and citizenship.

Finally, we highlight the need to overcome the productivist and market-oriented logic that permeates PHC, strengthening interdisciplinarity and the active participation of service professionals in collective actions. When social workers integrate actions such as these, their performance reaffirms their ethical commitment to building a more equitable and humanized SUS, meeting the real needs of the population, and promoting significant transformations in the clients' lives.

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