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Autoethnography essay by a social worker in primary health care

Ensaio autoetnográfico de uma assistente social na atenção primária à saúde

Ensayo autoetnografico de una trabajadora social en atención primaria de salud

ABSTRACT

Objective: To analyze the performance of a social worker in Primary Health Care (PHC) based on narratives produced within the context of a multiprofessional residency program in Public Health. **Methods:** The methodological approach is grounded in the reflective and critical exercise of autoethnography, allowing for the articulation between personal experience and theoretical-practical analysis. **Results:** The results highlight the insertion of Social Work in PHC, marked by structural tensions such as professional devaluation and precarious work, while revealing its centrality in guaranteeing rights, promoting comprehensive care, and mediating social demands. The main contributions are the strengthening of professional identity in health, the relevance of territorial, intersectoral, and multiprofessional action, and the need for an ethical-political stance coupled with addressing challenges. **Final Considerations:** It is concluded that autoethnography enhances the critical understanding of health practices by enabling the re-signification of experiences and the production of situated and reflective knowledge.

Keywords: *Social workers; Primary health care; Anthropology; Culture.*

RESUMO

Objetivo: Analisar a atuação de uma assistente social na Atenção Primária à Saúde (APS) a partir de narrativas produzidas no contexto da residência multiprofissional em Saúde Coletiva. **Métodos:** O percurso metodológico fundamenta-se no exercício reflexivo e crítico da autoetnografia, permite a articulação entre experiência vivida e análise teórico-prática. **Resultados:** Os resultados evidenciam a inserção do Serviço Social na APS marcado por tensões estruturais, como a desvalorização profissional e a precarização do trabalho, ao passo que revela sua centralidade na garantia de direitos, promoção da integralidade do cuidado

e mediação de demandas sociais. As principais contribuições são o fortalecimento da identidade profissional na saúde, a relevância da atuação territorial, intersetorial e multiprofissional, e a necessidade de posicionamento ético-político aliado ao enfrentamento dos desafios. **Considerações Finais:** Conclui-se que a autoetnografia potencializa a compreensão crítica das práticas em saúde ao possibilitar a ressignificação das experiências e a produção de conhecimentos situados e reflexivos.

Descritores: *Assistente social; Atenção primária à saúde; Antropologia; Cultura.*

RESUMEN

Objetivo: Analizar el desempeño de un trabajador social en Atención Primaria de Salud (APS) a partir de narrativas producidas en el contexto de un programa de residencia multiprofesional en Salud Pública. **Métodos:** El enfoque metodológico se fundamenta en el ejercicio reflexivo y crítico de la autoetnografía, que permite la articulación entre la experiencia vivida y el análisis teórico-práctico. **Resultados:** Los resultados resaltan la inserción del Trabajo Social en la APS, marcada por tensiones estructurales como la devaluación profesional y la precariedad laboral, al tiempo que revelan su centralidad en la garantía de derechos, la promoción de una atención integral y la mediación de las demandas sociales. Las principales contribuciones son el fortalecimiento de la identidad profesional en salud, la relevancia de la acción territorial, intersectorial y multiprofesional, y la necesidad de una postura ético-política que aborde los desafíos. **Consideraciones Finales:** Se concluye que la autoetnografía mejora la comprensión crítica de las prácticas de salud al permitir la resignificación de las experiencias y la producción de conocimiento situado y reflexivo.

Descriptores: *Trabajadores sociales; Atención primaria de salud; Antropología; Cultura.*

INTRODUCTION

Primary Health Care (PHC) is the main gateway to the Brazilian Unified Health System (SUS). It is the first care level and offers the best conditions for developing care practices through health promotion, protection, and disease prevention, diagnosis, treatment, rehabilitation, harm reduction, and the maintenance of population health[1]. In this context, interdisciplinary work is essential to ensure comprehensive care and to respond to the population's complex health needs.

The inclusion of social workers as health professionals was formalized by Federal Council of Social Work (CFESS) Resolution N°383/99 of March 29, 1999. Since then, they have been part of health teams, working in interdisciplinary fashion and intervening in sociocultural and economic situations while addressing the population's immediate needs, facilitating access to services, promoting access to rights, and supporting health promotion[2].

The work of social workers in PHC is highly relevant for the population. It is expressed in the guarantee of social rights and in mediating between users' needs and health services. According to Primary Care Handbook N°28, users also decide how they will access services, since health professionals are not the sole arbiters of health needs. This is aligned with the National Humanization Policy (PNH), which promotes receptive practices in health services in order to organize and harmonize relationships between professionals and users[1].

Despite the relevance of social work in PHC, major challenges still hinder the effective exercise of professional practice in this setting. Limited understanding of the profession's role, precarious working conditions, fragmented social policies, and increasing demand for services are among the obstacles faced on a daily basis. In light of this scenario, we should reflect critically on social work practice in PHC and seek strategies that can strengthen this work and contribute to improving health care.

Autoethnography serves as a methodological tool for professionals to critically analyze their experiences within their social, cultural, and institutional contexts. According to Santos[3], it facilitates recognition of how personal experience is shaped by group culture, contributing new knowledge and improving social work in public health.

In order to achieve this, the following study was conducted to analyze the work of social workers in Primary Health Care from an autoethnographic perspective. The object of analysis comprises professional experiences during a multiprofessional health residency at the Fernando Setúbal da Silva Family Health Unit, located in Tauá, Ceará, Brazil. By reflecting on these experiences, this paper seeks to understand the challenges, practices, and work processes of social workers in PHC.

METHODS

This qualitative autoethnographic study refers to self-reflective research connecting personal and cultural experiences. According to Minayo[4], this approach addresses a universe of meanings, motives, aspirations, beliefs, values, and attitudes, corresponding to a deeper level of relationships, processes, and events that cannot be reduced to the operationalization of variables. This method was chosen because it allows a deeper understanding of the researcher's experience as a social worker in Primary Health Care.

In this study, autoethnography described and analyzed the researcher's perceptions of her work as a social worker in PHC, relating her individual experience to her social, cultural, and institutional context through participant observation. Autoethnography here produced situated and reflexive knowledge that values the researcher's subjectivity and experience as important elements for understanding social reality. It also allowed a critical analysis of professional practice, thereby contributing to improved social work in public health, and the interpretive analysis was grounded in Minayo[4].

The study was conducted at the Fernando Setúbal da Silva Family Health Unit in the municipality of Tauá, Ceará state, Brazil. This unit has two teams, identified as Tauazinho I and Tauazinho II, and serves approximately 7,610 people, according to the Tauá Municipal Health Secretariat (2024).

The unit's staff comprises professionals from several fields, including doctors, nurses, nursing technicians, community health workers (ACS), endemic disease control workers (ACE), a manager, a receptionist, a pharmacy technician, and oral health teams composed of dentists and dental assistants. The unit also receives support from multiprofessional teams that include physical therapists, nutritionists, social workers, psychologists, a physical education professional, an obstetrician, a psychiatrist, and speech therapists.

Tauá's health network comprises PHC units, a municipal hospital, a Psychosocial Care Center (CAPS), a Center for Dental Specialties (CEO), a regional polyclinic, and diagnostic and therapeutic support services. The municipality is organized into health districts, which facilitate the management and organization of health services. Data were collected during the Multiprofessional Residency in Collective Health, from March 2024 to September 2025, using the following techniques:

1. Autoethnography: systematic recording of experiences, perceptions, reflections, and learning as a social worker in PHC by means of field diaries and detailed accounts of professional practice, seeking to capture the richness and complexity of experiences through a field diary[5].

2. Participant observation: the researcher actively observed and participated in the everyday life of the health unit, recording observations on relationships between professionals and users, work dynamics, challenges identified, and strategies developed. This technique allowed a deeper understanding of the context in which professional practice was embedded.

In autoethnographic studies, submission to a Research Ethics Committee may be waived when the investigation is strictly theoretical and based on secondary data in the public domain or on experience reports that do not involve the collection, handling, or disclosure of identifiable third-party data. In such cases, there is no exposure of human participants and no direct ethical risk requiring prior institutional review. Thus, for the present study, ethics committee review was considered unnecessary, in accordance with current guidelines for research of this nature.

RESULTS

This autoethnographic record sought to describe and analyze the work of social workers in Primary Health Care (PHC) based on experiences during a multiprofessional residency. The findings are consistent with the existing literature on the challenges and potential of social work practice in this field, while also offering a unique and situated perspective enriched by the researcher's personal reflection. Social workers seek to uphold rights and ensure that public policies function effectively, as reflected in the narratives extracted from this study's field diary:

Frame 1 – Field notes, 2025.

Date	**Narratives**
April 2024	"Today I saw a family living in extreme social vulnerability. The mother, unemployed and caring for three young children, reported difficulties in securing food for the children and accessing health services. I provided guidance on social rights, referred them to the social assistance network, and worked with the health team to ensure follow-up for the children. I can see how important the social worker's role is in securing access to rights and ensuring comprehensive care."
May 2024	"Working in PHC helped me understand the importance of territorial work and of getting close to the population's social reality. Home visits, community activities, and direct contact with users gave me a much deeper understanding of the territory's health needs and social demands."
June 2024	"Today I visited an adolescent with mental health problems. She lives alone with a child and is not taking the medications prescribed by the psychiatrist. The community health worker asked me to guide her on taking the medications and attending appointments at the Family Health Unit with the psychologist."
June 2024	"At today's team meeting, we discussed the case of a family facing multiple social vulnerabilities. I was able to contribute information on the social assistance network, on social rights, and on possibilities for intersectoral intervention. I can see how the social work perspective complements the

	perspectives of other professionals, helping build a broader and more comprehensive understanding of health needs."
July 2024	"Today I took part in a matrix-support meeting, contributing to and discussing the cases that were presented, and I realized how important it is to interact and work together to help people experiencing mental suffering."
July 2024	"Today I had difficulties coordinating an interdisciplinary action. Some professionals still have a fragmented view of care and are resistant to sharing knowledge and practices. I can see that building interdisciplinary work is an ongoing process that requires dialogue, respect, and a willingness to learn from one another."
August 2024	"Today I conducted a home visit to a family in a socially vulnerable situation. I identified several needs, such as food insecurity, inadequate housing, and difficulties accessing education. I provided guidance on social rights, referred them to the social assistance network, and worked with the health team to ensure follow-up for the family. I can see how important social work actions are for identifying and intervening in the social determinants of health."
September 2024	"Today, reflecting on my professional practice, I realize how fundamental social work in PHC is for securing access to social rights and for ensuring comprehensive care. By intervening in the social determinants of health, providing guidance on social rights, coordinating with the service network, and strengthening social participation, we help make the right to health effective and improve the population's living conditions."
October 2024	"Today I had difficulties coordinating an interdisciplinary action. Some professionals still have a fragmented view of the health-disease process, focused only on biological aspects, and resist considering the social determinants of health. I can see that building a comprehensive and broader view of health is an ongoing process that requires dialogue, awareness-raising, and continuing education."
November 2024	"Today I took part in a team meeting in which the specific role of the social worker in PHC was questioned. Some professionals still have a limited view of the social worker's role, associating it only with granting benefits or referring users to other services. I can see how important it is to strengthen professional identity, make the competencies and responsibilities of social workers more visible, and demonstrate in practice the specific contribution of social work to the multiprofessional team."
December 2024	"Today, while taking part in a community action, I realized how social workers are able to build ties with the community, understand its needs and strengths, and coordinate actions that respond to identified demands. This

	ability to articulate responses and understand social reality is an important strength of social work in PHC."
January 2025	"Today I participated in a continuing education activity on the social determinants of health. It allowed me to deepen my knowledge, reflect on my practice, and identify possibilities for improvement. I can see how continuing education is essential for the qualification of professional work and for building critical knowledge committed to social transformation."
February 2025	"Today, reflecting on my professional practice, I realize how fundamental the ethical-political dimension of social work in PHC is for guaranteeing the right to health and for building a fairer and more equal society. By defending users' rights, denouncing situations of rights violations, strengthening social participation, and contributing to democratizing access to health care, we bring the ethical-political project of social work into practice and contribute to social transformation."

Source: Prepared by the author, 2025.

Being a social worker resident in PHC: an autoethnographic experience

My experience as a social worker in PHC during the multiprofessional residency was marked by challenges, learning, and transformation. Direct contact with people's social reality, the relationships built with users and with the multiprofessional team, and the interventions in the territory provided a rich professional and personal experience.

When I began the residency, I stood before a complex setting marked by social inequalities, vulnerability, and difficulty accessing health services. Most people served by the health unit lived in substandard socioeconomic conditions, with low income and schooling levels, facing barriers to fundamental rights such as housing, food, education, and work.

In this context, the social worker's action was essential in identifying and intervening in health inequities, thus contributing to better living conditions and greater well-being for the population. This understanding was strengthened by observations made throughout daily life in the territory, which highlighted the complex social demands and the importance of qualified professional practice.

During the territorialization process conducted by the residents to get to know their forthcoming practice setting, a statement made by a community health worker particularly stood out. At the time, she commented that the work of the social worker in the unit had no clear usefulness, adding that tasks such as solving users' immediate demands or organizing the distribution of food baskets could be performed by other team members (field notes, March 2024). This statement revealed differing understandings of the social worker's role and highlighted ongoing challenges in the team's day-to-day routine regarding the

profession's responsibilities and potential within PHC, as well as the reduction of its work to mere 'welfarism'.

It became clear that some health unit professionals still do not fully understand the social worker's role as a key stakeholder in guaranteeing rights, guiding users, and articulating different service networks. This perception reveals the persistence of a conservative view of the profession, which, despite advances achieved over the years, persist in institutional daily life. Notably, the Social Worker's Code of Ethics establishes, among its principles, a commitment to equity and social justice, ensuring universal access to the goods and services of social policies and the defense of democratic management[5].

One of the most meaningful aspects of this experience was the opportunity to reflect critically on professional practice, identifying strengths, limits, and possible forms of intervention. This critical reflection was facilitated by autoethnography. It improved professional practice and built situated knowledge committed to social and cultural transformation.

In daily practice, it became clear that ACS frequently sought out the social worker to conduct home visits, although many of these requests involved demands that do not directly fall within this professional's core responsibilities. Even so, given the characteristics and needs of the territory, the social worker often ends up taking on and responding to such demands, seeking not only to provide immediate assistance but also to strengthen comprehensive care for users.

According to the legislation regulating the profession, some provisions distinguish general competencies from the exclusive responsibilities of social workers. Whereas competencies may be shared with other professionals, as in the case of home visits, exclusive responsibilities belong solely to the profession. In the example observed, the visit could have been shared with the multiprofessional team, such as the psychologist, to provide guidance on appropriate medication use, while the social worker could have focused on guidance related to care for the child living in the household.

It also became clear in several situations that requests for home visits were motivated by an attempt to 'scare' users, which is incompatible with social work's ethical principles and essential functions. In this sense, a proper professional perspective and qualified listening can make all the difference in daily work and in professional practice.

The autoethnographic experience also revealed challenges in professional practice, such as poor working conditions, fragmented social policies, service bureaucratization, and growing care demand. These challenges required creativity, resilience, and ethical-political commitment in order to ensure quality care and the effective realization of users' rights.

In the catchment area, a high demand was observed among bedridden older adults who needed medication and diapers for their daily care routine. Notably, despite the constant submission of reports requesting these supplies, bureaucratic processes hinder access within the service. As a result, not all users

are covered, and long waits and significant delivery delays are common, compromising care continuity.

DISCUSSION

The social worker's role within the multiprofessional team

The inclusion of social workers in PHC multiprofessional teams represents a major advance for the profession. During my experience, I observed that interdisciplinary work effectively improved the quality of care and the problem-solving capacity of health actions. My role within the team involved understanding the health-disease process, identifying vulnerabilities, providing guidance on rights, coordinating intersectoral responses, and strengthening social participation, as recorded in my field diary in June 2024.

The multiprofessional team at the health unit is organized into two groups, Tauazinho I and Tauazinho II, because of the large number of users served, and a third team is being planned to expand coverage. Each group includes professionals from different fields, such as doctors, nurses, nursing technicians, community health workers, dentists, physical therapists, nutritionists, psychologists, and others. Diverse knowledge and practice favors a broader and more comprehensive approach to the population's health needs and strengthens the quality of care provided in the territory.

These experiences suggest that interdisciplinary work in PHC requires the construction of horizontal and dialogic relationships among professionals, respect for the specificities of each field, and a willingness to share knowledge and practice. During my experience, I observed both strengths and challenges in this process. In the team's daily routine, the number of users kept growing with the expanded territory. One challenge social workers face is the lack of an exclusive room for appointments, despite walk-in and continuous demand. The professional often has to share a room or often wait for a chance to use another professional's room.

According to CFESS Resolution N°493, social workers have the right to conduct appointments in an appropriate room that ensures professional confidentiality and allows records to be stored in cabinets with exclusive access. However, the conditions observed in the territory were inadequate for this purpose. It is also common for care to be delivered in a shared format, both during home visits and in matrix-support activities, which compromises privacy and the effectiveness of professional practice[6].

Matrix support, a strategy used in PHC especially for the follow-up of mental health cases, aims to promote comprehensive care for users and their families. At the health unit, this practice usually takes place twice a month on Thursdays, when the multiprofessional team meets to discuss cases previously selected by Family Health doctors together with the psychiatrist. This approach

favored the collective construction of care strategies and strengthened interdisciplinary work[7,8].

It was also clear that difficulties in the exercise of the profession are common in daily work. Among the challenges, I would highlight the coordination of different bodies of knowledge and practice, the hierarchical nature of professional relationships, fragmented care, and work overload. The social worker's role within the multiprofessional team is also linked to the National Humanization Policy (PNH), which values the different subjects involved in the production of health, the establishment of supportive bonds, and collective participation in management processes[9]. In this context, the professional contributes to more humanized care, a receptive stance of users' demands, and the construction of more horizontal and dialogic relationships between professionals and users.

The multiprofessional residency, with its service-based training model, represented a privileged space for the development of interdisciplinary work. Daily coexistence with professionals from different fields, participation in joint activities, and multiprofessional supervision broadened understanding of the health-disease process and helped develop competencies for teamwork.

In short, the social worker's work within the PHC multiprofessional team is essential to comprehensive care. It requires the construction of horizontal and dialogic relationships among professionals, respect for the specificities of each field, and a willingness to share knowledge and practice. Despite the challenges, the experience within the multiprofessional team proved enriching and transformative as it improved professional practice and enhanced care for users.

Professional actions and social demands in the territory

The work of social workers in PHC is closely tied to the territory's social demands and to the population's health needs. During my experience at the health unit, I identified several social demands requiring social work intervention and developed professional actions aimed at addressing them. The main demands observed in the territory included:

1. Difficulties in accessing health services: Many users faced geographic, economic, cultural, and organizational barriers to health care. These difficulties were related to the distance between home and the health unit, lack of transportation, incompatibility between the unit's opening hours and users' availability, lack of information about the services offered, among other factors.

2. Socioeconomic vulnerability: Much of the population served lived in precarious socioeconomic conditions, marked by low income, unemployment, underemployment, food insecurity, inadequate housing, and difficulty accessing basic rights such as education, social assistance, and social security.

3. Domestic and family violence: cases of violence against women, children, adolescents, older adults, and persons with disabilities were identified

and required immediate intervention and coordination with the social protection network.

4. Harmful use of alcohol and other drugs: the territory showed a significant incidence of problems related to the harmful use of alcohol and other drugs, affecting individual and collective health, family relationships, and community dynamics.

5. Difficulties adhering to treatment: many users struggled to adhere to health treatments, whether because of socioeconomic factors (lack of resources to buy medicines, travel to the health unit, or follow specific diets) or cultural and educational factors (limited understanding of the importance of treatment, beliefs, and values that interfere with adherence).

6. Fragile social support networks: Many users, especially older adults, people with disabilities, and people with mental disorders, had weak social support networks and needed support to carry out daily activities and access health services.

In response to these demands, I developed several professional actions that can be organized according to the guidelines of the Health Care Networks (RAS) as a strategy for comprehensive care, acting through politico-organizational processes, planning and management processes, and social and welfare processes.[10] Within politico-organizational processes, I highlight the following actions:

1. Social mobilization and participation: I implemented actions to mobilize the community to participate in social control spaces such as the Local Health Council and the Municipal Health Council, seeking to strengthen users' participation in SUS management.

2. Health education: I developed educational activities on social rights, public policies, social determinants of health, and other themes, seeking to contribute to users' awareness and empowerment.

3. Intersectoral articulation: I established partnerships with other sectors, such as education, social assistance, culture, sports, and leisure, seeking to develop integrated actions and expand the possibilities of intervention on the social determinants of health.

Within planning and management processes, I highlight:

1. Action planning: I participated in planning the health unit's actions, contributing a social work perspective to identify needs and define intervention strategies.

2. Practice systematization: I systematized professional practice by means of records in medical charts, reports, field diaries, and other instruments, in order to contribute to the visibility and recognition of social work in PHC.

3. Evaluation of actions: I participated in evaluating the actions developed by the health unit, contributing to the identification of strengths, limitations, and possibilities for improvement.

Within social and welfare processes, I highlight:

1. Receptive and qualified listening: I received users and engaged in qualified listening, seeking to understand their needs, demands, and potential, and to establish bonds of trust and respect.

2. Guidance on social rights: I provided guidance on social rights, public policies, and available services, seeking to facilitate users' access to their rights.

3. Referral to service networks: I referred users to social assistance, health, education, social security, and other service networks, seeking to ensure access to the services and benefits they needed.

4. Home visits: I conducted home visits to understand users' social reality, identify vulnerabilities and strengths, and develop actions involving guidance, referral, and follow-up.

5. Individual and family care: I provided individual and family care, seeking to understand the specific needs of each user and family and to develop actions involving guidance, referral, and follow-up.

These professional actions were developed in articulated and complementary fashion, seeking to respond to the social demands identified in the territory and improve the population's living and health conditions, as recorded in the field diary. In short, they encompass political and organizational processes, planning and management processes, and social and welfare processes, in order to ensure guaranteed access to social rights, comprehensive care, and better living and health conditions for the population.

Reflections on professional practice

My autoethnographic experience as a social worker in PHC provided a rich opportunity to reflect on professional practice, grounded in the ethical-political project of social work and in a commitment to guaranteeing rights, thereby improving my practice and building situated knowledge committed to social transformation.

One of the most significant aspects of this reflection was understanding how important social work in PHC is for securing access to social rights and ensuring comprehensive care. The reflective process identified challenges in daily professional practice, such as substandard working conditions, fragmented social policies, service bureaucratization, rising car demand, and difficulties in intersectoral articulation. These challenges required creativity, resilience, and ethical-political commitment in order to ensure quality care and the effective realization of users' rights.

As recorded in the field diary, one of the most significant challenges was the need to overcome the fragmented and reductionist view of the health-disease process that still persists in many health services. Another important challenge was the need to strengthen the professional identity of social workers in PHC within a context of disputes over spaces of action and questioning of the specificity of professional work.

Reflecting on practice also identified strengths and possibilities for transformation. Regarding the former, I highlight the social worker's ability to understand users' needs, coordinate service networks, strengthen social participation, and contribute to more humanized care. Concerning the latter, I emphasize the importance of continuing education, professional supervision, research, and systematized practice for improving professional performance.

The autoethnographic experience allowed reflecting on the importance of the ethical-political dimension of social work in PHC. This dimension is expressed in a commitment to defending social rights, democratizing access to health care, and promoting equity and social justice. This exercise improved my practice, building situated knowledge committed to social transformation, and strengthening the ethical-political project of social work. The critical reflection made clear how important this work is for guaranteeing access to rights and reaffirmed the profession's commitment to defending SUS and building a fairer and more equal society.

One of the central points in this discussion lies in the complex PHC setting, marked by social inequalities and vulnerabilities that directly affect people's health. I observed that the population served frequently faces poor socioeconomic conditions and difficulties accessing fundamental rights such as housing, food, and education. This finding is consistent with the understanding that health is a multifaceted event influenced by factors that transcend the biological sphere[11]. In this context, the work of social workers is crucial for identifying and intervening in these determinants in order to improve users' living and health conditions, aligned with SUS principles[12].

The study also highlighted a persistence culturally limited view of the social worker's role in PHC, even among other health professionals. The statement made by one ACS, who questioned the usefulness of social work beyond the delivery of food baskets, illustrates the ongoing need to demystify and strengthen professional identity. This distorted perception can hinder the profession's full integration into multiprofessional teams and limit recognition of its competencies and exclusive responsibilities, as established by the Profession Regulating Law[5]. I also underscore the importance of taking a clear stance in favor of equity and social justice, ensuring universal access to goods and services and the democratic management of social policies.

Substandard working conditions, fragmented social policies, service bureaucratization, and work overload were recurring challenges identified in professional practice. The lack of an adequate space for appointments that guarantees confidentiality and secure document storage as provided for in CFESS Resolution N°493 is a concrete example of unsuitable working conditions[6]. Such obstacles require professionals to be creative, resilient, and firmly committed on ethical-political grounds in order to ensure quality care and the effective realization of users' rights. The critical reflection facilitated by autoethnography was a valuable tool for identifying strengths and limits and for improving professional practice.

On the other hand, the autoethnographic experience revealed the importance of territorial work and of coming closer to the population's social reality. Home visits and direct contact with users allowed developing a deeper understanding of health needs and social demands in the territory. This approach values qualified listening and reception, is fundamental for building trusting relationships and implementing actions that respond to local specificities[12].

In this regard, the social worker's contribution – through articulation with the social assistance network, guidance on social rights, and strengthening of social participation – complements the work of other fields and promotes more humanized care, aligned with the PNH[9]. However, hierarchical professional relationships and resistance to sharing knowledge still represent challenges to the construction of truly interdisciplinary work.

The professional actions developed were categorized into politico-organizational processes, planning and management processes, and social-assistance processes. They reveal the breadth and relevance of social work in PHC. From social mobilization and health education to reception, guidance, and referral to service networks, social workers act as a key link between users and the health system, seeking to guarantee access to rights and improve living conditions[13]. The systematization of practice through records and reports is essential to the visibility and recognition of this work[14].

In a nutshell, autoethnography enabled a deep reflection on professional practice, reinforcing the importance of social work in PHC for guaranteeing the right to health and for building a fairer and more equitable society. The challenges identified were significant but point to the need for ongoing investment in training, supervision, and professional recognition, as well as in the promotion of effective and humanized interdisciplinary work. This experience shows that, in the face of adversity, social workers play an irreplaceable role in promoting comprehensive care and defending social rights within PHC.

FINAL CONSIDERATIONS

The activity of social workers in PHC, as revealed through the rich and complex experiences of a multiprofessional residency, reinforces the relevance of the profession within public health and offers a situated and reflective perspective on the challenges and potential of this practice. This study highlighted the profession's irreplaceable role in health-related interventions and showed that social workers are a crucial link in ensuring access to social rights and in pursuing comprehensive care for a population marked by vulnerability.

The challenges identified – such as the persistent limited view of social workers' competencies, inadequate working conditions, and fragmented social policies – indicate the need for a continuous effort to value and recognize the profession. Such barriers require an unwavering, resilient, and creative ethical-political commitment from professionals in defense of the profession's ethical-political project.

At the same time, the potential of social work practice becomes evident in territorial activity, intersectoral coordination, and active participation in multiprofessional teams, where qualified listening, guidance on rights, and community mobilization reaffirm the social worker as an agent of social transformation, essential to humanized care and to the realization of SUS principles.

From an autoethnographic perspective, the multiprofessional residency experience strengthens the field of social work in health by consolidating professional identity, making visible the breadth of the profession's competencies and responsibilities, and providing support for management and continuing education. It also highlights the need for adequate working conditions and horizontal interdisciplinary practices, while encouraging the use of reflexive methodologies such as autoethnography for the continuous improvement of practice and the production of situated knowledge.

Yet this singularity is also the study's greatest strength, since it paves the way for future research that can replicate and expand autoethnography in different PHC contexts in order to broaden these reflections and intervention strategies. The researcher's autoethnographic journey stands as a testimony to the daily struggle to materialize the ethical-political project of social work within the everyday reality of SUS.

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