

# Continuing Health Education: the experience of social work with Family Health Teams

Educação Permanente em Saúde: a experiência do serviço social com Equipes Saúde da Família

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**ABSTRACT** – Continuing Health Education provides for building collective knowledge within health services and has in Family Health Multidisciplinary Residency the potential for creating moments of reflection. Continuing education workshops were conducted with professionals from a Family Health Unit in the northern region of Londrina/Paraná, where a team of residents was working. This study structures thoughts on the role of social workers in these workshops, especially the discussions of a socio-political nature, in which the social worker was a facilitator. It was conducted using the participant research technique, lasted for ten months and the subjects were health workers at the above-mentioned unit. It can be concluded from the findings that socio-political reflections were not carried out with the necessary amplitude for these services and that social workers can contribute so that these can be affirmed as elements for changing the way health care is provided.

**Keywords** – Continuing Health Education; Multidisciplinary Residency; Socio-political relations; Social work.

**RESUMO** – A Educação Permanente em Saúde prevê a construção de conhecimentos de forma coletiva no interior dos serviços de saúde e tem na Residência Multiprofissional em Saúde da Família potencial para a criação de momentos reflexivos. Foram realizadas oficinas de educação permanente com os profissionais de uma Unidade Saúde da Família da região norte de Londrina/PR, local em que atuou uma equipe de residentes. Esse estudo estrutura reflexões sobre a atuação do assistente social nessas oficinas, sobretudo, as discussões de caráter sociopolítico, em que, o assistente social foi facilitador. Foi realizado sob a técnica de pesquisa participante, se estendeu por dez meses e os sujeitos foram os trabalhadores da referida unidade. Infere-se nas conclusões que reflexões sociopolíticas, não têm sido realizadas com a dimensão necessária nestes serviços e que o assistente social pode contribuir para que se afirmem enquanto elementos de mudança no fazer saúde.

**Palavras-chave** – Educação Permanente em Saúde. Residência multiprofissional. Relações sociopolíticas. Serviço social.

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Changes in health care are an imperative and challenging necessity and Continuing Health Education provides a powerful strategy for accomplishing this. From this perspective, one of the dimensions of incorporating multidisciplinary residents in health services, integrating them into the work processes of Family Health Teams, is involvement in teaching processes on the basis of the reality experienced by health workers.

This paper presents reflections on the activities of a team of Family Health Residents, specifically the role of a social worker, in the interaction and creation of reflective spaces of a socio-political nature, considering that such spaces provide a crucial perspective for consolidating the SUS (Unified Health System) and the affirmation of health as a social right.

Nevertheless, discussions of a socio-political nature within health services deal with the commitment to health, more specifically, with the commitment in defense of the SUS, which expresses an intention to re-politicize health care with the goal of consolidating Brazilian health reform and thereby secure the SUS as a public policy (BRASIL, 2006).

This paper formulates reflections in respect to Continuing Health Education, Social Work in health care and Multidisciplinary Residency in Family Health, on the need for a collective building process of educational activities, on how the rationale of capitalist accumulation is reproduced in daily life and was expressed in the discussions.

### **Continuing Health Education and socio-political aspects**

A longstanding demand of movements that seek quality health care for the country is continuing education for workers that operate in public health care. One of the main features that consecrated this need within a national context was the constitutional guarantee, which makes the State the guiding agent in the training process of health workers (BRASIL, 1990).

The prerogatives engendered by constituents heightened the need for professional development. The Constitution, by catalyzing different social demands that preceded it, caused a shift in the conception of social individuals, now understood as subjects with social, political and civil rights. These factors, coupled with the creation of the Unified Health System (SUS) and the Family Health Program in the 1990s, were the basis for understanding that the profile of health care workers was "inadequate" for meeting the new demands (MOURÃO, et al. 2007, p. 370) and that it would be necessary to create a National Policy for Continuing Health Education, enacted in 2003.

This inadequacy refers to the training model still in force, which is Flexnerian in nature: fragmented, highly specialized, with little emphasis on prevention and health promotion, centered on hospitals. Although this training contributes to structuring the medical-industrial complex, backed up by norms that favor the hiring of private services and oriented towards generating profit, consolidated in the 1970s and 80s, it is funded almost entirely with public funds (CAMPOS, 2006, p. 5).

By establishing health care as a right and the responsibility of the State in the Constitution of 1988, there was a shift in terms of the role of the State, which took on the function of guiding and managing Brazilian health policy, as well as the operationalization of health care services through the model of universal, decentralized, integrated and participatory health care, as advocated by the SUS.

In this sense, these are new positions that federal agencies have come to occupy in designing public health care in the country, as well as the demands that users generate in health services, making the issue of training health workers a real and legitimate one.

Continuing Health Education is a policy that serves health workers and seeks to transform work processes on the basis of meaningful learning,<sup>1</sup> i.e., existing knowledge, pre-established values and the

power and organizational structures of the current work are given importance in health care practices, together with critical reflections about such work, using as a reference health-related needs of individuals and communities, and that such be invested with meaning, both for users and workers. It is noteworthy that technical and professional updating is only one element of training (BRASIL, 2003).

Nevertheless, if Continuing Health Education has the potential to change the professional profile of health workers, it is buttressed by a counter-hegemonic perspective and framed within a societal project. In this regard, Ceccim and Feuerwerker (2004) argue that training is a necessary social task and can overcome crystallized conservative positions in society and health services:

[...] it must uphold ethical and political commitments in regards to society. As a bearer of the future, [...] it cannot be tied to traditional values, but to the flow of changes within society, and should be able to astutely monitor values in the process of transformation (CECCIM; FEUERWERKER, 2004, p. 49).

Discussions that give rise to change in society are fundamental in the educational processes of health care workers. We consider social change, specifically in health care policy, as the consolidation of paradigms for providing health care linked to social determinants, which deny Flexnerian approaches.

The overall health of a population is the result of more general conditions such as socioeconomic, cultural and environmental ones in reference to life, work, etc. Within this perspective, health interventions need to broaden the scope for social determinants, taking into consideration the inclusion of class as a central determinant. Thus, working with social determinants can contribute to changing an ontologically unequal society, by incorporating spheres of material production and reproduction, class structures, cultural and symbolic constructions, among others, and proposing actions of a macro-social nature for its confrontation (BARATA, 2009).

Vocational training, understood as a historical process, reveals the ongoing relationship between the worker and the work process (PEREIRA; RAMOS, 2006) and is, therefore, linked to the work category. Human labor is the means by which man transforms nature and at the same is modified. According to the logic behind capitalist accumulation, the worker is obliged to sell his labor-power, thus becoming a commodity (MARX, 1981).

This category undergoes modifications according to changes in society and the progression of the capitalist mode of production. In contemporary times, it takes on a complex conformation in light of the internationalization of capital and the fragmentation of the working class: those deprived of the means of production, including wage earners, the unemployed, temporary workers, agricultural workers, etc. It is reaffirmed, nevertheless, that work is still central to understanding social reality (ANTUNES, 2005).

In the interpretation of health care work, it can be noted that it operates primarily with relationship technologies, of subjectivity (soft technology), in addition to equipment and technologically structured knowledge (hard and soft-hard technologies, respectively) (MERHY, 1997). It is knowledge that is built in an essentially tacit manner. Despite attempts by capital to also expropriate this kind of labor, with the imposition of targets and productivity, the worker can institute changes, since he still owns the work process and can exercise activities from an emancipatory perspective within the micropolitics of living work (MERHY, 1997).

In the contemporary interpretation, knowledge is also understood as a commodity or productive force (PEREIRA; RAMOS, 2006, p. 15). In this respect, professional qualification ascribes more value to the labor commodity, i.e., qualification "fetishizes" the commodity as "value in addition to its own worth" (PEREIRA; RAMOS, 2006, p. 15).

With the advent of the so-called restructuring of production and its flexible accumulation processes (HARVEY, 1993), education takes the shape of a guarantee of inclusion, whether through the "myth of the diploma" – in which having a diploma means a job with social assurances, ignoring the reality of the workplace and its consequences for all workers – or through the acceptance of lighter, uncritical and instrumental training received, which moves an expanding and profitable market for private schools at the technical and university level, many of them in the form of distance learning, or

also for the maintenance of the labor market. Herein there are offers of specialized courses, MBAs and other alternatives for increasing knowledge, in both cases attributing "being employed" to individual skills. Thus, education is used for competing for employment, to the detriment of training for long-term work (PEREIRA, 2008).

Knowledge produced under the aegis of capitalism ensures the expropriation of workers and higher extraction of surplus value. It tends to be an adjustment factor for individuals, maintaining relationships of domination or making the organization of the working classes innocuous. These arguments may explain the preponderance of quick training sessions that are reduced to a mechanical qualification that workers undergo in their workplaces. Now, if it is in favor of capital that professional education is linked, does it make any sense to wager that it can be a factor for social change and attribute public policy status to it?

Pereira and Ramos (2006) corroborate this by pointing out that, although they are produced and reproduced by capital, workers can be critical and utopian as appropriate forms for conceiving multiple social expressions are built. Thus, training can serve "as a counter-hegemonic tool against capitalism [...], a powerful instrument against the culture of barbarism, in order to combat existing destructive impulses" (PEREIRA; RAMOS, 2006, p. 15).

In order to give rise to an effective possibility of changes in health care and in the capitalistic rationale, it is necessary to understand the structures on which hegemonic social values are built and founded, in other words, a process of political and social education. Discussions of this order are referred to in this study as "socio-political. For Chauí (2000):

When historians talk about education, they refer not only to economic, social and political determinations that produce a historical event, but they also think in terms of transformation and, therefore, the continuity or discontinuity of events, perceived as temporal processes. [...] the record of education is history itself, including its representations, either those that are aware of the historical process or those that conceal it (CHAUI, 2000, p. 9).

The ideology of political education that we are addressing is reproduced in the perspective of training offered in Multidisciplinary Residency in Family Health and aims to be a transformational movement through work.

### **Notes on Multidisciplinary Residency in Family Health (MRFH)**

The educational training process proposed for residences is oriented toward in-service training. Training initiatives of this nature are mainly adopted in professions related to the area of health. The genesis of Multidisciplinary Residencies dates back to the 1970s (CAMPOS, 2006, p. 5).

The devaluation of primary care and the hegemony of the Flexnerian model were factors that weakened the community-based residency movement focused on primary care, according to the reflections of Da Ros et al. (2006). In 2000, there was an intention to rebuild residency processes in Primary Care, the driving force behind Multidisciplinary Residency in Family Health (MRFH).

At the same time, this model aims to incorporate and qualify the specificity of each profession involved and develop a common field of knowledge, with Primary Care as a place for building a collective and community-based work in order to intervene effectively in the health of populations and contribute to the work process of health units, with integrated and intersectoral actions (CARVALHO; LIMA; BADUY, 2006). Thus, the inclusion of social work is of fundamental importance for achieving these goals due to the nature of its intervention in health care.

## The paths of Social Work in health care policy

Social Work was incorporated into public health in the early nineteenth century, inserting itself into hospitals and linked to fragmentary, individual and welfare perspectives, as well as being subject to the doctor, (BRAVO, 2007, p. 33). Professional activities were in line with the vision that prevailed in the category within this context, aimed at the adjustment of individuals and regulation of the clientele.

The role of the social worker underwent changes arising from an internal process in the profession, combined with changes that occurred in health care. The internal process dates back to the movement that reconceptualized social work in Latin America from the 1960s to 1975 and questioned traditional social work tied to the American model, its purpose, rationale, ethical and political commitments, procedures and training (IAMAMOTO, 2008).

As a legacy of this movement (IAMAMOTO, 2008), social work in Brazil in the late 1980s and early 1990s was a protagonist of the so-called tendency to break away from traditional social work (NETTO, 1996). One of the important consequences of this intended rupture, besides the theoretical and methodological repercussions, was the Ethical-Political Project of Social Work.<sup>11</sup>

This new theoretical and methodological contribution of the profession, which could be considered prevalent, makes incisive criticisms of the State, initially dictatorial and now neo-liberal, and of the dismantling and fragmentation of public policies; it aims to contribute to the building of effective universal policies, among them a health care policy.

In the context of public health, the change in the conception of health and the results of the critical stance of the agents of health care reform enabled the expansion of the "clinic", the proposal of interdisciplinary work and the understanding of health and illness as socially determined processes (PAIM, 2008). Despite the progressive nature of the health reform movement, with very similar characteristics to the vision built on the intention to break away, the social work profession remained, in the 1980s, distant from the health reform movement (BRAVO; MATOS, 2007).

Also according to these authors, in the 1990s, with the neoliberal offensive in health care, the privatistic project was reaffirmed as opposed to the health reform project, both requesting a differentiated positioning of social work: the first, a regulatory, welfare-oriented and individual action; the second, democratic, humanized and interdisciplinary actions (BRAVO, MATOS, 2007, p. 206).

Operating Parameters for Social Workers in Health Care were recently elaborated for the profession, with the goal of guiding professional practice. This document contemplates the work of social workers in the training of health care workers (CEFESS, 2009). Also, in other documents, this professional characteristic is reaffirmed through linking these activities as political-organizational actions of the professional practice of social workers (MIOTO; LIMA, 2009).

Nevertheless, social workers figure among the professions of the Family Health Support Centers (NASF), a government policy that emerged on the national scene in 2008, which gives multidisciplinary teams the responsibility to engage in continuing education initiatives (BRASIL, 2008). These factors reaffirm the necessary reflection of the activities experienced by social workers as residents in health units, as well as in areas of continuing health education.

## Health services as a place for the production of reflective practices

The implementation of the Multidisciplinary Residency in Family Health in Londrina/Paraná had the goal of enabling residents to contribute effectively toward changing the work process of the Family Health Teams in the units in which they were allotted. Seven professions were included in the make-up of residence, namely: a social worker, dentist, nurse, pharmacist, physiotherapist, psychologist and physical education professional.

The Aquiles Stenghel Health Care Unit, the setting for this research, located in the northern region of the city of Londrina (Paraná), structures its activities on the basis of attending patients according to spontaneous and elective demand, in addition to procedures pertaining to the family health

strategy. Three Family Health Teams work in the unit, each one consisting of four to six community health agents, two nursing assistants, a nurse and a general practitioner.

We observed the incidence of turnover in the teams during the research period; there were resignations by workers, new hires, maternity leave, vacation, among others. These factors together result in the heterogeneity of the teams, both in terms of time and experience working in the Family Health Strategy and in academic, technical and complementary training. The issue of personnel turnover in Family Health Teams has already been the subject of studies and its implications for work effectiveness, care and the link between the team itself and the users have been pointed out (MEDEIROS et al., 2007; CAMPOS; MALIK, 2008).

Between October 2008 and December 2009, weekly workshops were held with the workers from the three teams that operated there, organized by the residents, in order to discuss issues affecting the work process. Topics dealt with: teamwork; mental health; health promotion; social issues and social safety nets; sheltering; dental care.

The challenge the residents faced was structuring such discussions on the basis of so-called meaningful learning, which from the viewpoint of Continuing Health Education means conducting discussions based on work, going beyond the mere transfer of information and using teaching resources that encourage worker participation and interaction, taking into account their specificities and the knowledge that individuals already possessed (BRASIL, 2007).

The preparation and facilitation of three meetings were assigned to social workers. In addition to reflecting the practice of social work and its possible contributions to the Family Health Strategy, their goal was to structure reflections of a social and political nature, aiming to contribute to the construction of a more critical and reflective professional profile.

This study is based on participatory research, with a qualitative approach. We chose this methodology with the understanding that it favors interaction between the researcher and members of the situations being investigated, which contributes to a more fruitful interpretation (GIL, 2008).

In this manner, both the researcher and the subjects of the study intervene with the knowledge of reality. However, it affords the researcher greater autonomy, since he is not necessarily bound to a rigid data collection instrument (MINAYO, 2000). The data sources utilized were: field logs, reports prepared by residents, and a planning and evaluation tool applied to workshop participants.

The data was interpreted using the technique of content analysis based on the thematic analysis categories: (a) Continuing Health Education: a collective process; (b) the daily (in)visibility of the social issue expressions; and (c) the inexorability of capital.

Since this research involved people, the project was evaluated by the Bioethics Committee of the State University of Londrina, receiving consent under number: 271/08. Each subject was informed of the research objectives and signed a Consent Form – two copies – one remaining with the participant and the other held by the researcher.

### **Continuing Health Education: a collective process**

Health care work is essentially collective, and as such, composed of unique individuals who take on distinct occupational areas and powers. The sovereignty of health actions is still centered around the doctor, and even in the Family Health Strategy, in which a nurse heads up the coordination of the teams, a physician still controls the work process with his/her technical and social authority (NOGUEIRA, 1991). These factors cement the traditional verticalization of imposed and normative health actions, in addition to distancing reflection and integration from the work process, thereby losing the richness of diversity.

The National Policy for Continuing Health Education has been structured to operate as a collective process so as to ensure the participation of different agents in achieving it (CECCIM, 2005). In practice, difficulties resurface in rendering this proposition concrete. Even though incorporated within

the routine activities of the Unit, workers participated little in the idealization and planning of the workshops, which remained in the hands of the residents.

Most of the subjects in the intervention only had contact with the activities once the final configuration was ready. One of the finest elements in regards to health education, according to Ceccim (2005), is thinking about health in a teaching and learning network within the exercise of work; in other words, educational activities should be oriented towards daily health care actions.

Thinking together about the activities enhances the effective participation of workers, who can then see themselves as co-participants throughout the work. Nevertheless, in accordance with Cecílio (2007), we believe that the "moral worker" will most likely not adhere to changes in the work process if they perceive their autonomy to be threatened, however noble the intention behind the change may be.

Interventions of a vertical nature in the work process are crystallized in the daily life of workers, such that there were few objections to what was proposed. The three teams were presented with a detailed schedule and available spaces for contributions and objections, but only one offered more incisive criticism of what was being proposed, requesting changes and a reorganization of the schedule.

Democratizing the planning, evaluation and management of projects, with the aim to overcome the vertical tradition and thereby incorporate the body of workers, as well as users, is perhaps nowadays one of the biggest challenges in the implementation of public policies and contains possibilities for rising above the vision which reduces workers to a mere resource for running programs.

An impediment to effecting Continuing Health Education as a collective activity is the fragmented work in the context of the productivity and predominance of health care actions, which makes it difficult to conceive of times of reflection and training as part of the work process, as seen in statements such as: "It's hard to leave work to come here" (nurse).

This statement coincides with assertions that suggest the discomfort of leaving the "demand" on account of others. It also indicates the refraction of the context of health care labor, the strenuous activity, long hours and the overall number of professionals that is insufficient to meet the number of people seeking health services (ARIAS et al., 2006). This factor was striking in the responses to the evaluation tool. When asked about the commitment to the proposed activities, the "demand" or "work in the health unit" were used as justifications for not attending some workshops.

Another interesting point is how absenteeism is criticized by teammates in the workshops: "I would like for everyone to participate from beginning to end" (unidentified deponent). If on the one hand these declarations express the difficulty of effecting a collective agreement, they also bring forth the ideological model of teamwork, engendered by flexible accumulation, whose precise intention is to make workers themselves exercise mutual control, demand productivity and reduce absenteeism (HARVEY, 1993).

It should be noted, however, that the non-participation of medical professionals was not a point of concern on the part of the team, considering that only one team could count on the participation of the physician during the workshops. The failure of the teams to question this situation can be attributed to the social representation built around this professional, as well as the value given to the "few hours" that this category remains at the Health Unit, i.e., the time the physician has needs to be earmarked for priority activities.

Concerned about the continuity of the process that was initiated, there was an agreement made with the workers that the space built constituted a weekly time where teams could come together to organize their work and engage in training.

It is important to have the presence of an agent who can articulate the health education sessions, since workers still find it difficult to organize themselves in this regard. Thus, those sessions cited above took place and were reinforced by the residents through educational activities, such as reading texts and reflecting on the work process, as well as their specific professional contributions for dealing with particular situations.

## Daily (in)visible expressions of the social issue

In order to trigger reflections on the rationale of social inequality, we used symbolic figures, associated with income distribution data in Brazil and the discrepancy between economic development and social development in order to provide solidity to the ideology behind the social issue.<sup>11</sup>

Workers, in seeing the materialization of the inequality and exploitation inherent in the existing mode of production, have been able to elaborate, albeit in an incipient form, criticism of the social structure, relating the situations they deal with at work to macrosocial conditions, as indicated by the assertions "increased demand in the health unit" (nurse), violence, exclusion and the like.

This attitude is apparently paradoxical, since, when viewing the unfolding of the social reality, reflected in audiovisual constructions, workers reacted with surprise, saying they did not realize how cruel reality was for the most impoverished ranks in society. In other words, when asked, they are able to infer that this reality exists and reproduces itself, but they fail to identify it in their daily work activities or in the reality in which they live, since community health agents live in neighborhoods attached to the Health Unit.

However, the economic scenario insists on classifying men into social groups and strata according to income and authorizes their self-classification within these categories, as well as causes a separation from and fracture of the notion of being men who share the same condition of workers. Consequently, it distances health workers from the users they serve, not only because they have jobs, salaries and other goods, but also due to their difficulty in understanding and identifying the social construction process of how men live and construct reality.

Isolated in their individuality and unable to perceive themselves as being generic and universal, thus bearing an identity common to all men, the understanding and place of each one in society is measured by their ability to own goods and consume, and those who do not enjoy access to the same are relegated to the tough conditions of everyday life with the hardships of work, housing, food, health, and so on.

We concluded that the concerns that the social reality produces are not properly addressed. Reflections of this kind are essential to the work process, in order to overcome the naturalization of inequality that is reproduced in a socio-historical process of adaptation of individuals to the rules of civilization, however "uncivilized" such rules may be (HOBSEBAWM, 1998), that is, as inequalities grow deeper, society adapts by making them invisible; likewise those moments of shock when confronted with appalling situations that usually appear in the media are caught up in the gears of adaptation and contribute to hide how much individuals have become accustomed to normality (HOBSEBAWM, 1998).

Therefore, we believe that an educational process, also directed towards socio-political issues, could be a factor that would enable workers to view from another perspective the social and health conditions that people are subjected to and, consequently, would cause a shift in the way the health needs of individuals are addressed and interpreted. This outlook is justified, since the Family Health Strategy aims to provide assistance for demands of a social nature and, as Vasconcelos reflects (2008, p. 147), "it is not enough to simply stir up or engender a new willingness among professionals. It means creating educational and reflective spaces within the institution."

## The inexorability of capital

*But so what? I'm outraged and now? (Community Health Agent)*

One of the instruments used by capital to maintain the existing order is the movement of ideological production which ascribes the current means of production with adjectives that are impervious, eternal and, in the words of Ramos and Pereira (2006), inexorable:

[...] certain homogeneity of discourses that tend to convince us of the inexorability of the capitalist mode of production and the triumph of market forces over any project focused on the possibility of overcoming social classes (PEREIRA AND RAMOS, 2006, p. 65).

The statement of the Community Health Agent cited at the beginning of this sub-section was made during discussions which were questioning the capitalist order and, for this purpose, we read a text which, set within the last financial crisis and the Influenza A (H1N1) epidemic, denounced the crisis in the capitalist system and indicated the need for the organization of the working class which acquired greater significance in the discussion.

This demonstrates what Antunes (2005) refers to, in regards to the difficulty of reconstructing together with workers the notion of belonging to a class, which capitalism repeatedly tries to blur, as workers express total ignorance of the existing potential in organizing and fighting for class interests, in addition to the removal of formal venues, such as management councils and unions. The weakening of trade unionism and the organizing of the working class, the subordination and alienation of popular movements that challenge the status quo – or intend to do so – are *sine qua non conditions for strengthening the rationale of the capitalist system for the adjustment of the restructuring process complex* (ALVES, 2000).

It should be noted the distancing from issues dealing with the overcoming of capital, and in general the discredit arising from the perpetuation of the dominant logic, as expressed in the testimony that raised the issue of election campaign expectations and the reality of the prevailing government at the time, "we had hope with Lula, but look how it turned out" (nursing assistant). Associated with political disillusionment, individualism turns the social issue into particular problems and, thus, distant from the collective reality.

Mézáros (2006) points out that society is built through the actions of private individuals seeking their own ends; however, these individuals engender their own reproduction and, thus, also reproduce a certain form of dominant production. In this sense, for the major problems and questions that the capitalist system presents, there are few answers and indications of a rupture given the weight of inequality it produces, causing a kind of conformity in terms of overcoming it. At most, the possibilities for its revision are set forth in topics, with more humane and acceptable characteristics.

Such considerations indicate that the production of health care necessarily entails the criticism of that society and its human sociality. Confronted with the daunting task of thinking and reflecting on how to break the bonds that the capitalist system imposes, many prefer silence and the lethargy of their living room in front of the TV, or the vaccination rooms, immersed in daily life and abdicating their social responsibility in the face of needed change in society.

## Final considerations

If, at the center of the dispute between health projects, the Family Health Strategy has a privileged place, together with the democratic project, Continuing Health Education is a fundamental tool to further build the SUS, in terms of how it was conceived and registered in the legal apparatus that legitimizes it. Therefore, it is necessary to rethink the models of health education.

That study demonstrated such a need and indicated possibilities for action linked to an innovative proposal with the understanding that workers can be utopian, purposeful and protagonists of effective change in regards to providing health care and in the current social structure.

It can be inferred from that study that the educational task is more likely to be carried out if it is connected to daily professional life and organized within health care work itself, linked to workers, enhancing progressive actions and tendencies and strengthening the class struggle within health services. We also conclude that discussions of this nature have not been conducted on the needed scale to the

point of being themes for effective change in the workplace; to the contrary, Continuing Health Education, in health services, has been reduced to technical-operational training and sporadic/organizational changes in work processes.

As far as Social Work is concerned, it can be seen that – although not being an exclusive prerogative of this profession – educational actions and reflective processes of this nature can be built by this professional, given his education and the ethical-political project of the profession, buttressed by an emancipatory perspective.

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- <sup>i</sup> Meaningful learning is structured on the basis of the problematization of men in their relationship with the world. It is motivated by the active desire of participants; the appropriation of new knowledge and practices; “through the prior and personal experiences of the subjects, inciting the desire to learn more” (CECCIM; FERLA, 2008, p. 163).
- <sup>ii</sup> Professional projects present the self-image of a profession, select the values that legitimize it socially and delimit and prioritize its goals and functions. In the case of social work, the societal project proposes the construction of a new social order, without exploitation/domination of classes, ethnicity and gender. It is established in the Curriculum Guidelines, the law that regulates the profession and professional code of ethics (NETTO, 2007).
- <sup>iii</sup> Social issue is understood as the expressions of the training and development process of the working class and its entry into the political scenario of society, demanding its recognition as a class on the part of the business community and the State. It is the manifestation, in everyday social life, of the contradiction between the proletariat and the bourgeoisie, which now demands other types of intervention beyond charity and repression (IAMAMOTO; CARVALHO, 1983, p. 77).