

Integrative and complementary practices and the relation to health promotion: the experience of a municipal healthcare service

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This study addressed the integrative and complementary practices developed at a reference service in the metropolitan region of Belo Horizonte/MG, Brazil. It analyzed how the practices developed in this service were organized and focused on their relationship with health promotion and how they fitted into the Brazilian National Health System (SUS). The results indicated that these practices could be useful resources for health promotion, especially because they establish new understanding of the health-illness process, in a more holistic and empowering manner. However, to boost them within the fields of health promotion and SUS care, challenges relating to organizing and expanding the services need to be surmounted and professionals within the reference services and specialized support for integrative and complementary practices within primary healthcare need to be brought closer together, so as to construct a common field of care.

Keywords: Complementary therapies. Integrative Medicine. Health Promotion. Primary Health Care.

Introduction

Complementary and alternative medicine is defined as a group of different medical and healthcare systems, and also of practices which are not present in biomedicine¹.

The World Health Organization² uses the expression Traditional, Complementary and Alternative Medicines to define the set of practices and therapeutic actions that are not present in biomedicine.

In the literature, there are different names for therapeutic practices; however, in Brazil, the expression *práticas integrativas e complementares* (PIC - integrative and complementary practices)³ is used. This designation has spread since the approval of the *Política Nacional de Práticas Integrativas e Complementares* (PNPIC – National Policy for the Integrative and Complementary Practices), in 2006, which includes Traditional Chinese Medicine (mainly Acupuncture), Homeopathic and Anthroposophical Medicine, Medicinal Plants (Phytotherapy), and Social Hydrotherapy (Crenotherapy)³.

It is also possible to consider the relation between the PIC and the Health Promotion National Policy⁴, as health promotion can be understood as a field of proposals, ideas and practices that has been increasing in public health and which is based on a broad conception of the health-disease process and of its determinants. Health promotion proposes the articulation of technical and popular knowledge and the mobilization of institutional and community-based, public and private resources to tackle the health-disease process⁵. The inclusion of the integrative and complementary practices in the *Sistema Único de Saúde* (SUS – Brazil's National Health System) is an action that expands the access and enhances the qualification of the services, in an attempt to involve integrated care to the health of the population⁶. The importance of Primary Care to strengthen health promotion practices, especially the PIC, should be highlighted.

However, there are still difficulties concerning the implementation of the practices in the SUS, mainly because of insufficient data on production and research, and also because of limitations in the control of such practices, among others^{2, 4}. Thus, the development of the integrative and complementary practices in the Brazilian public health network has been undergoing a slow expansion process⁶. In addition, there is little accumulated knowledge on the forms of organizing, adapting and including the PIC in the SUS, both in Primary Care, and in matrix support services (*Núcleo de Apoio à Saúde da Família* – NASF – Family Health Support Nucleus) and/or reference services (secondary care, specialized services).

This paper aims to present and discuss results of a research study that analyzed the organization of the PIC developed in a PIC reference service located in the metropolitan region of Belo Horizonte, State of Minas Gerais (Southeastern Brazil), focusing on their relation to health promotion and on their inclusion in the SUS.

Methodology

This is a descriptive and exploratory study that uses the qualitative approach whose framework is dialectics. Dialectics is a strategy to learn about reality that apprehends and understands the social empirical practice of individuals within society⁷.

The empirical field was a municipal healthcare Service specialized in integrative and complementary practices and in health promotion practices. The Service is located in a municipality of the Metropolitan Region of Belo Horizonte, State of Minas Gerais, and its population is estimated at 81,162 inhabitants⁸.

Data collection was performed through observation and semi-structured interviews with the professionals who work in the Service, with the aim of understanding their organization. All the six professionals who work in the Service were interviewed: two homeopaths, one acupuncturist, one holistic therapist, one occupational therapist and the Service's manager.

In addition, the *Cadastro Nacional dos Estabelecimentos de Saúde* (CNES – National Roll of Healthcare Establishments) and the *Sistema de Informações Ambulatoriais* (SIA – Outpatient Information System) were consulted to complement the analysis stage, in order to obtain information on the healthcare establishment and the Service's outpatient production of procedures. The CNES is the roll of the health information systems and it registers aspects of the functioning of the healthcare establishments in the federal, state and municipal spheres. The SIA offers instruments to register the calculation of the outpatient production, data targeted at the management of installed and produced capacity, etc. For the present study, the number of procedures in the Service was selected in the period June-November 2012. These databases (CNES and SIA) were accessed between February 1 and February 11, 2013.

For the analysis of empirical data, the thematic content analysis was employed, being guided by Bardin's proposal for data organization⁹. The research complied with Resolution 196/96 of the Ministry of Health and it was approved by the Research Ethics Committee of *Universidade Federal de Minas Gerais*, Opinion no. 0481.0.203.000-11. The subjects were informed about the study's aims and purposes and signed a consent document.

Results

Characteristics of the municipal Service of integrative and complementary practices

The municipal Service of integrative and complementary practices was inaugurated in 2008 as a Specialties Center (reference center) for Health Promotion and includes integrative and complementary practices. Assistance is provided exclusively for users of the SUS and it functions during the day.

The Specialties Center was registered in the *Cadastro Nacional dos Estabelecimentos de Saúde* (CNES – National Roll of Healthcare Establishments) in 2010 as a service of integrative and complementary practices that has an agreement with the SUS. It provides outpatient assistance in the public healthcare network, with municipal and state management.

The interviewed professionals were the six professionals who work in the Service. These professionals are characterized by different professions and have been working in the Service for different periods of time, as it is shown by Table 1. All the interviewed professionals have university degrees. Among them, five have degrees in some specialty of the integrative and complementary practices: two in Homeopathy, two in Acupuncture and one in Holistic and Community Therapy. The professionals' number of working hours is diversified, without exclusive dedication to the Service, except for the Manager. Three of the professionals are public employees, two have been hired, and one has a commissioned position.

The professionals who work in the Service are enrolled in the National Roll of Establishments according to their occupations, in agreement with the Brazilian Classification of Occupations of professionals in integrative and complementary practices: Occupational Therapist; Holistic Therapist; Acupuncturist; Homeopath; and Healthcare Services Manager.

Practices offered in the Service of Integrative and Complementary Practices

The data analysis enabled us to identify five practices offered in the Service: Homeopathy, Acupuncture, Memory Workshop, Senior Dance and Relaxation. In addition, it was possible to map the assistance capacity: the number of patients assisted per month, as shown in Table 2.

However, the procedures carried out in the Service of Integrative and Complementary Practices are registered in the outpatient production of procedures, in the SIA, as acupuncture session with needling; medical consultation in specialized care; educational activity/group orientation in specialized care.

According to the data in the SIA, in the period from July to November 2012, there were 356 acupuncture sessions with needling, 508 medical consultations in specialized care and only four educational activities/group orientations in specialized care.

Description of the offered practices

The practices of Homeopathy and Acupuncture are performed in the form of individual consultations; the Memory Workshop, Senior Dance and Relaxation are collective practices, performed in groups.

In the Homeopathy assistance, individual consultations last between 30 minutes and one hour. In these consultations, the professional listens to the individual's main complaint, and he/she also approaches issues related to the individual's childhood, family, relationships, fear, sorrow,

sleep, cold and heat, among others, as aspects to be investigated in the diagnosis of this medical rationality¹⁰. Subsequently, the homeopath, in the assistance process, searches for a therapy based on homeopathic medicines, usually consulting an electronic Manual (software). The homeopath enters the symptoms and the software identifies the homeopathic medicines that are “similar” to the individual. The first homeopathy consultation must be scheduled personally at the Service or the patient must be referred by a healthcare professional. The organization of the supply of Homeopathy in the studied Service establishes, almost always, returns every two months and the participants can remain in treatment for an indeterminate period. During the fieldwork, no processes of therapy discharge were identified. Thus, there is a permanent dependence on professional knowledge to maintain the harmony or the reestablished balance.

In Acupuncture, first there is an individual consultation, when the anamnesis is performed and the individual's complaint(s) and characteristics are identified, as part of the process of diagnosis of the medical rationality that guides this practice. There are also orientations regarding the needling sessions, a therapeutic procedure that is exclusive of the traditional Chinese rationality in the study's scenario. Then, the needling sessions are carried out, totaling a cycle of twelve sessions. In this practice, assistance is provided on a weekly basis, and the session lasts approximately twenty minutes. These needling sessions are performed during a period of approximately three months, until the twelve sessions are completed. This number of sessions was established as one of the rules by the practice instructor, as he mentions that with eight to ten sessions, the majority of participants will present satisfactory results; also, it is necessary to offer the opportunity of assistance to other people. Another rule is that the individuals can have a maximum number of three absences from the acupuncture sessions. This rule was instituted with the aim of reducing the queue.

Memory Workshop and Senior Dance are practices carried out in closed groups whose meetings occur on a weekly basis and last sixty minutes. As the dynamics of these two practices is based on closed groups, the individual can only be included in a group at the beginning of the practice's cycle. The only restriction to be included in the practices of Memory Workshop and Senior Dance is that the participant cannot present cognitive deficits.

The Memory Workshop is structured in ten meetings. From the first to the third one, information on memory is given and indications to stimulate memory in daily life are provided. From the fourth meeting onwards, practical activities are performed, such as: game of the seven errors, numeric sequence with a missing number, reading of words by the instructor followed by notes made by the participants. Thus, the participants remain until they attend the ten meetings. The maximum number of participants in the group is ten individuals.

In Senior Dance, aspects of musicality and rhythm are developed, in addition to memorization of choreographies. The dance is performed within a group, and the participants remain in a circle, sometimes sitting, sometimes standing. During the activity, the individuals work with their bodies through choreographies created from instrumental songs and rhythmic

movements. The groups change annually and are composed of up to twenty participants. In this practice, the participants must memorize the choreographies and pay attention to the musical rhythm.

Relaxation is constituted of different moments: it begins with the participants sitting in a circle, talking about themes related to life experience, relationships, and health information, and also about themes mentioned by the participants themselves. Subsequently, the relaxation technique is introduced, and it is always accompanied by a quiet and relaxing music. Frequently, exercises of self-massage and dances are associated in the activities to complement the practice. It was observed that faith, independently of religion, is present in the dynamics of this practice, either in the moments in which the group prays, in songs sung by the participants, and/or in the thanks that are given at the end of the practice.

The empirical data show that access to the practices offered by the Service occurs through referral by other healthcare professionals or by spontaneous demand; only in Acupuncture, "entry" is exclusively determined by medical referral. In the other practices, Homeopathy, Memory Workshop, Senior Dance and Relaxation, inclusion occurs through the two forms of access – spontaneous demand or referral -, but there is no imposition of medical referral, as there is in Acupuncture.

The findings show that the demand for the PIC is high, mainly for Homeopathy and Acupuncture, as exemplified below:

[...] as you can see, here I'm the only one to the entire municipality... So, almost always there is a demand, the queue is of one or two years. A large pent-up demand [...]. (E3 – Acupuncturist).

My referral to Acupuncture has been here since 2010 and I was called only now. (Conversation with a participant in the service, Field Diary, 03/13/2012).

The two homeopaths confirm the acupuncturist's considerations when they reveal the challenge that they face to meet the demand. Due to this, it was necessary to establish criteria of access to the practices (in the case of Acupuncture, access is granted only through medical referral and each individual is entitled to twelve sessions). Therefore, it is possible to infer that, as medical referral is required, the individuals will necessarily present some symptom or underlying pathology that justifies this conduct.

It is important to mention that the Service is undergoing a process of decentralization of the practices of Memory Workshop, Senior Dance and Relaxation to Primary Care, focusing on the *Equipes Saúde da Família* (ESF – Family Health Teams) and on the *Programas de Agente Comunitário de Saúde* (PACS – Community Health Agent Programs). Therefore, the practices of

Homeopathy and Acupuncture would continue to be centralized. It is important to highlight that the Service intends to amplify the supply of PIC, including other activities, like Lian Gong, Yoga, Tai-Chi-Chuan, Shiatsu, Tui-Na and phytotherapy.

Integrative and complementary practices and health promotion

The empirical data allowed us to identify the conceptual imprecision that health promotion assumes in the professionals' discourses. When they were asked about the relationship between integrative and complementary practices and health promotion, the professionals answered by relating them to the prevention of health problems, thus strengthening a preventionist logic that is typical of the biomedical paradigm. In this context, the following terms said by the professionals stood out: "evitarem" (to avoid), "preventivas" (preventive), "levar informação para os grupos" (provide information for the group) and "informar" (to inform).

[...] first, the patients that we treat here are not people who are cognitively ill. So, it would be a way for them to avoid a more severe disorder or even for them to know about this issue of education and information. For example, in the Memory Workshop, they learn how to identify the symptoms of forgetfulness and relate them to a severe disease or not. (E1 – Occupational therapist).

I think that these integrative practices are all basically preventive. Of course that all of them help to cure the disease, but when we talk about, for example, massage, I think that a treatment like massage, yoga, meditation, relaxation, among others, does help the person in that moment in which... in the disease they are facing. But I think that preventive medicine is really the most important. (E6 – Homeopath).

In the specific case of my workshop, I always listen to the people and I try to provide the group with information. So, when there's a subject that I have no knowledge about, in view of the need to provide an explanation, I always consult with other professionals who have that knowledge and I transmit it. So, I try to inform and exchange information in the group in all senses [...]. (E2 – Holistic therapist).

The data from the interviews reveal that health promotion assumes, in the professionals' discourse, the role of stimulating changes in life or behavior habits:

[...] I always listen to the people and I try to provide the group with information. I also think that we're always encouraging the practice of physical exercises, good nutrition, as well as the emotional aspect [...]. (E2 – Holistic therapist).

Homeopathy and all such practices... will make the person discover that I am the author of my life, I will change, and from this moment onwards, he starts to change his posture and his behavior. (E5 – Homeopath).

The highlight was the holistic conception, which can characterize one of the contributions to potentialize the PIC in the sphere of health promotion. In this aspect, the professionals mention the importance of understanding the individual in a holistic way, when they search for the reestablishment or enhancement of health as signs of the way of being and living:

I think that it has a very positive result, people are usually stronger when they get out of here. I say that they are stronger, both from the point of view of pain and from the psychological one. We always try, in every patient, I treat the pain he was complaining about, but we always try to balance his emotional aspect, because it is totally connected. A patient who is depressed, his pain is much more intense than that of the patient who isn't. So, what I notice is that the patients get out of here feeling more secure, stronger. (E3 – Acupuncturist).

It is also possible to state that the studied practices favor the individual's empowerment, as the professionals noticed that the individuals started to be empowered towards having greater control over their own lives, improving their self-esteem and being responsible for their life and health:

Now I'm changing my posture. I do what I want to do. Sometimes, I need to go out to think... I comb my hair and go [...]. (Register of the field observation in the researcher's diary, 05/31/2012).

[...] First of all, you show to the person that she can feel better, that there is a way for her to feel better, and you help the person to be responsible for her treatment. (E2 – Holistic therapist).

However, the study's findings offer only a little contribution to the understanding of the potential of the studied practices for the intervention in social determinants, which constitutes a

challenge to the field. We identified, in the professionals' discourses, elements that reveal that the practices impact not only on the subject, but also on the family that surrounds him/her. Thus, some practices are able to involve the family, in an attempt to reestablish the family balance:

We don't want that just the patient suffers less; we want that everybody who is around him also suffer less. Because there are patients who torment their families due to the disease. It's not because of the disease itself; these are people who have a difficult temperament and when they are ill, they become even worse. So, what we want is the balance of the whole family. (E6 – Homeopath)

However, this is still restricted to the family cycle and does not advance to the collective and social spheres. It was found that, to potentialize the promoting aspects, it is necessary to change the social sphere, or at least, its critical thematization. Nevertheless, this change is still seen as a "utopia", as the interviewed professional sees the attempt to change the health model as being based on experiences lived by individuals in a habitual way, within their daily life, so that they start to learn how to deal with their new world.

My dream is – when I arrived here, I even talked about his – my dream is to transform, in the future, even if it takes about five hundred years, my dream is that the thought, this way of thinking - I'll call it homeopathic, but in fact it's inherent in all practices – is included in school, in primary education. Changing a person who is seventy years old is much more difficult, making him have a more active posture. It's much easier to shape a person who is six years old within this way of thinking: that the disease comes from the inside, and how I've been relating to people. We should know how to teach and express our feelings without attacking the other. Teaching how to listen. [...] and the only thing left are the diseases for us to break this paradigm. But I think that it would be necessary to have the discipline "health" in the classrooms, let's be healthy and teach this. [...] the paradigm has been changing, I believe this will happen, scientific thought is changing [...]. (E5 – Homeopath).

Although an intersectoral approach is fundamental to make health promotion practices advance, this element is still a challenge in the investigated Service. The data show that the Service is not related to other sectors of the municipality; it has only a proposal for partnership with a NGO. The partnership or articulation with PACS and ESF professionals is still limited, as the professional goes to the catchment area of these healthcare units to develop the practice.

Discussion

The results indicate that the practices of Memory Workshop and Senior Dance are integrative and complementary practices; however, the classification adopted in the PNPIC does not specify them, and they can be designated as therapeutic resources^{11, 12}. According to the PNPIC, the integrative and complementary practices are a field that includes both complex medical systems and therapeutic resources³.

Therefore, the lack of definition of what is understood as PIC in the PNPIC characterizes a difficulty and a challenge to the inclusion of such practices in the SUS Services. The PNPIC has favored the visibility, in the health information systems, of the practices that were being developed, but it has not explained what can be registered as PIC. Many practices have not been included in the PNPIC and do not have codes in the forms of the CNES and SIA; thus, the professionals who perform them make the register separately¹³.

It is worth discussing that, beyond complex medical systems (medical rationalities), especially in the contemporary context, there is a multiplicity of health practices that are not necessarily based on a medical rationality, or other practices that complement biomedicine. Therefore, it is important to obtain a clearer definition of this complex field.

The practices offered in the study are registered in the Outpatient Information System as specialized activities, acupuncture session and educational activity/group orientation in specialized care. Thus, the data analysis shows that the Information System does not apprehend all the practices offered in the Service. There is a mismatch between what is practiced by the professionals in the Service and what is registered in the Information System, and this may cause underreporting of data and, consequently, it can impact on the monitoring and evaluation of the practices and services specialized in PIC¹³.

Another element of analysis refers to the contributions of the PIC to the field of health promotion. Cintra and Figueiredo¹⁴, as well as Tesser¹⁵, show the potential of the PIC for health promotion. However, the findings of our study show the imprecision of the health promotion concepts held by the majority of the professionals, as they understand health promotion as disease prevention. This has also been found by other authors^{16, 17}. Beyond prevention of health problems and health education, health promotion is a broad concept that enables the individual to exercise his/her autonomy and achieve better life conditions.

Moreover, the PIC affiliated with vitalistic medical rationalities have their own notions about health promotion which, unlike the conceptual field in vogue in public health, discussed by Carvalho¹⁸, allow an integration between promotion and cure, that is, health promotion includes, in many situations, the treatment of diseases (remarkably in the area of mental health)^{15, 19}.

This logic shows the importance of integrating the PIC Service with Primary Care, with the purpose of potentializing health promotion, as Primary Care encompasses care, disease prevention, and also health promotion.

It is important to mention that the health promotion practices aim to overcome the excessive fragmentation in the approach to the health-disease process, strengthening intersectoral articulations and promoting integrated care²⁰. To achieve this, they are supported by the principles of holistic conception, empowerment, social participation, equity, multi-strategic actions, sustainability and also by the intersectoral approach²¹.

The highlight in the analysis was the holistic conception, whose element is directly related to a broad and positive understanding of health. The holistic conception, in the scope of health promotion actions, enables to stimulate physical, mental, social and spiritual health, and involves a broad conception of health²¹. The vitalistic medical rationalities and their practices are structured and act in terms of a positive conceptualization of health. Thus, they provide health promotion techniques, knowledge and actions, and sometimes, they integrate into them therapeutic care, stimulating cure potentials and strengthening health¹⁵.

It is also possible to mention the studied practices' potential for contributing to the individual's empowerment, as this element is a central axis in health promotion.

"Psychological" empowerment aims to strengthen self-esteem, the capacity to adapt to the environment, and the development of mechanisms of self-help and solidarity¹⁸. Nevertheless, it is possible to notice, in the findings of the study, that there is little mention to collective approaches that point to social and political participation or that consider community empowerment. Community empowerment is understood here as a possibility that individuals and the collectivity have of developing competences that can be shared in societal life, including skills and reflective thought about public policies¹⁸.

It is important to highlight that the search for the practices happens by means of the individual's perception of what is being offered by the Service. With this, the major part of the demand is constituted based on the supply, that is, the individuals demand only the practices that can be obtained in the Service. Therefore, the individual's demand is socially constructed and is related to the Service's profile and to the way in which care is provided²². Thus, it is possible to infer that access to the Service and, consequently, to the PIC, is still not universal, as the Service does not offer many practices, and it has a reduced number of professionals and little capillarity, in view of its characteristic of a Service with centralized practices. Therefore, the findings allow to state that there is a mismatch in the relation between the supply of the practices and the demand of the population, with restricted access determined by the professionals' availability. Other authors have also shown that the assistance offered by the PIC professionals is still insufficient in light of the high demand, which would require, for its expansion, some operational planning²³.

The high demand for the PIC can represent advances in the cultural movement that views these practices as more than a form of treating diseases. In this sense, the population can "spontaneously" search for them, as a citizenship right. This can signal an advance towards overcoming biomedicine, as it indicates that there are changes in the cultural and symbolic

representation of health practices that admit new forms of treatment other than medicinal and surgical measures, which are typical of contemporary Western medical rationality.

It is worth emphasizing the possibility of expanding the PIC to Primary Care. The Family Health Strategy is pointed as the structuring axis of Primary Care in the Brazilian National Health System. It is a strategy to promote the expansion of the PIC, and it represents a complex challenge to awareness-raising and qualification regarding the PIC²⁴. Primary Care has the unique specificities of being the preferential service for the citizen's first contact with professional healthcare, and having as its mission the integration of actions of care for diseases, prevention of health problems and health promotion. Moreover, it is the natural place for the inclusion and development of the PIC in universal Health Systems²⁵. So much so that, according to research carried out by the Ministry of Health, 72% of the PIC offered in Brazil were included in Primary Care, with intense participation of the Family Health Strategy²⁶.

Another significant element to be highlighted is the importance of Primary Care for the process of expansion of the PIC and for strengthening health promotion. It is in this level of care that sufferings and diseases are, many times, in the initial stage, a moment in which it is possible and desirable that there are therapeutic actions and also actions to strengthen self-care and the people's potential of self-cure and rebalancing, which has been recognized as a strong point specifically of the PIC and of the other medical rationalities²⁷.

Our findings contribute to the discussion about the increase in the supply of PIC in the national scenario as a structural aspect of the phenomenon of expansion of such practices in society and corroborate other studies that have shown the use of these practices in public healthcare services as an element of advance in the field^{14,16,23}. However, this advance, in the case of specialized services, has been very limited, given its little coverage, the distance from the disease and from people's socio-familial, existential situation, the long queues and their relatively large isolation, aspects that make these services specialized in PIC (or medical offices of some PIC inside specialized outpatient clinics) be limited to few techniques offered to few people - remarkably, people with chronic diseases that see the PIC as the last resource.

As valuable as the techniques involved may be, this situation of concentration of professionals specialized in PIC (pure professionals, in the terminology of Barros²⁸, as they do not practice biomedicine simultaneously with PIC) in specialized services, overlapping with the other healthcare professionals who already exist, greatly limits the PIC's potential for enriching the collection of knowledge and practices to be offered to the population that uses the SUS.

The direction pointed to overcome this serious limit comes from the very tendency of the new institutional arrangements and of the matrix practices, like the NASF, which potentially enrich the Primary Care practices and foster the permanent education of their professionals. Such arrangements and new practices of joint work provide greater interdisciplinarity and concrete partnerships between professionals from different *nuclei of competences*²⁹ in the individual and/or collective assistance provided for users who need more complex care (than the care that can be

more easily provided by the ESF “alone”). In these arrangements and with matrix support, it is possible to generate the progressive construction of a common field of PIC competences shared by Primary Care/ESF professionals (and by professionals from other services), so that the PIC are transformed into one more interpretative and therapeutic resource (and a health promoting resource) of the Family Health teams, in a depth level that will not exhaust, of course, all the potentialities of the PIC. Therefore, these professionals will be “hybrid”: they will practice biomedicine and PIC. A recent experiment regarding the expansion of the PIC into the ESF, using the competence of professionals who already worked in the services (who may be from Primary Care, from specialized services or from the NASF) – supported and organized by the municipal management – as instructors of their colleagues, proved to be promising in this sense⁶.

Another simple and forceful argument in favor of the need to think of strategies of permanent education in PIC for Primary Care/ESF professionals (and even for professionals from hospitals, emergency services and others), is the fact that it is not possible to offer the PIC massively to the users of the SUS with “pure” professionals, neither in Primary Care nor in specialized backup services. It is neither possible nor recommended that Primary Care has, apart from the doctor-nursing team, one homeopath, one massager and one acupuncturist to each citizen who benefits from this; rather, generalist doctors and nurses will have their practice greatly enriched if they learn homeopathy, acupuncture, yoga, relaxation, massage, reiki, etc.

The degree of qualification and depth of this learning will vary according to the situations and people involved, but it should be the largest one that is possible to achieve within the institutional possibilities and personal interests. Obviously, specialized professionals will be necessary to enable such permanent education and qualification, and these professionals will also be more demanded in their specific competence nuclei (within their medical rationalities or their own techniques), as the PIC are disseminated in Primary Care.

Thus, the NASF or the specialized services have their place in the SUS if they are closely linked to and partners with their colleagues, who refer patients to them in a personalized way, and if they participate in schemes of qualification, supervision, matrix support and case discussion, so as to enable the permanent and continuing education of the professionals in charge, thus building the common field of care in the PIC and the *coordination of care* by Primary Care³⁰. Without this, PIC specialists in specialized services will only be some more professionals among the myriad of specialists through whom users build their therapeutic itineraries inside the SUS and outside it, who do not talk to each other (in general, medical specialties and the other health professions).

Final remarks

The study enabled to analyze the organization of the PIC developed by a specialized municipal healthcare service, as well as their relation to health promotion.

Despite the incentive of the PNPIC to the implementation of the practices in the network of services of the SUS, especially in Primary Care/ESF, it is concluded that there is the challenge of understanding and building which health practices can be included in the scope of the PIC. In addition, it should be noted that the current Information System does not apprehend all the practices offered in the services. With this, there is a mismatch between what is practiced by the professionals in the Service and what is registered in the Information System.

However, the PIC can be useful resources in health promotion, mainly because they establish a new understanding of the health-disease process in which the holistic perspective and individual empowerment stand out, with impacts on the subjects' daily life. Nevertheless, to potentialize the practices in the field of health promotion and of care in the SUS, it is necessary to overcome the challenges referring to a sectorialized practice that is essentially individualistic and which tends to be limited, restricted and with difficult access, in the case of "pure" specialized services and professionals, like the ones investigated here. They provide a small contribution to the expansion of the access to the PIC and to the construction and qualification of the common field of care and of health promotion in the SUS and in Primary Care/ESF.

Collaborators

K. M. S. V. Lima and K. L. Silva were responsible for conceiving the research, collecting and analyzing the empirical data, and for revising and writing the final version of the paper. C. D. Tesser was responsible for discussing the data, revising and writing the final version of the paper.

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