

Monitoring the implementation of a Municipal Policy on Complementary and Integrative Practices: the main challenges

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Abstract: This paper is an excerpt of an ethnographic study conducted within a doctoral program in a Complementary and Integrative Practices referral unit located in Peruíbe-SP, Brazil. It presents an analysis of the implementation of a Municipal Policy on Complementary and Integrative Practices (MPCIP), including participant observation of meetings held with workers and managers, field diaries, documents from the Brazilian Ministry of Health and the World Health Organization, legislation, and reports of those involved. The analysis was based on hermeneutic interpretation (GEERTZ, 1989), and the main challenges faced during the process are presented. Even though the format of the MPCIP in Peruíbe meets national and international requirements, it only warranted legal-institutional aspects. Despite advancements in policy development, there remain political and operational challenges to its implementation and expansion, which shall be overcome to fully implement Complementary and Integrative Practices in the city's health service.

► **Palavras-chave:** complementary and integrative practices; complementary therapies; ethnography; Unified Health System; health policy.

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Introduction

This paper is an excerpt of a qualitative and ethnographic study addressing the relationship between pain and distress, monitoring patients with chronic pain and receiving treatment with Acupuncture and Therapeutic Touch, along with their respective therapists in a referral unit providing Complementary and Integrative Practices (CIP) located in the city of Peruíbe, south coast of São Paulo, Brazil.

With approximately 65,000 inhabitants, Peruíbe is a seaside town that belongs to the metropolitan region of Baixada Santista, Brazil's largest area of primary Atlantic rainforest. Its Black Mud deposit, which has been used for approximately two decades in thermal treatment and balneotherapy, gave the city its naturalist tradition. Black mud of Peruíbe is rich in organic and mineral elements, with positive effects in the dermatology and rheumatology fields (MACEDO, 2018; TORRECILHA, 2014; BRITSKA, 2006).

In mid-2001, there was a great demand for the treatments initially provided in tents on the seafront. In 2004, the Lama Negra Thermal Park (Black Mud Thermal Park) was built in a privileged region close to the ocean with a facility containing stretchers, bathtubs, chaise lounge chairs, and a solarium. Options for treating the different conditions included treatments implemented on a stretcher without sunlight, a chaise lounge chair, immersion baths in the solarium, or outdoors under the sun. The treatments were complemented with thalassotherapy (sea bathing) (MACEDO, 2018).

The thermal complex was established in the early 2000s, consolidating the health tourism in Peruíbe, with an initial investment made by the city government. The physician in charge of the project is, until today, a naturalist, specialist in Thermalism and Phenology, Homeopathy, Phytotherapy, and Traditional Chinese medicine.

For political-ideological reasons, the treatments were suspended during the previous term, when the city government at the time, disregarding the importance of these activities, stopped paying and renewing the contract with the mining company that operated the deposit. The site remains in operation but only with the application of facemasks and video presentations for advertising purposes.

Despite political issues that interrupted the thermal complex treatments, the city's naturalist tradition paved the way to establishing public policies on CIP. The physician responsible for the complex had the initiative to propose this policy based

on two factors. The first was the implementation in Brazil of the National Policy on Complementary and Integrative Practices (NPCIP) through decree MS SUS 971, May 2006 (BRASIL, 2006), which set out the parameters and encouraged the dissemination of policies in states and cities. The second factor was associated with the *Movimento Popular de Saúde* (MOPS) [Popular Health Movement].

Like other popular movements, MOPS emerged in the 1960s with an initiative of the civil society. The Catholic Church supported it with the Basic Education Movement (MEB) and Paulo Freire's Liberation Theology (BONETTI; PEDROSA; SIQUEIRA, 2014). MOPS recruited volunteers from public universities, the student movement, and public health institutions, seeking to solve the health problems faced by vulnerable populations not protected by institutional actions. That is, MOPS followed on the heels of other movements such as the Brazilian Health Reform, which contributed to the establishment and emergence of the Brazilian Unified Health System (BONETTI; PEDROSA; SIQUEIRA, 2014; OLIVEIRA, 2009; STOTZ; DAVID; UN, 2005; STOTZ, 2005).

MOPS' primary focus is to share life experiences, valuing and using popular and traditional knowledge. According to these principles, CIP were included in the MOPS' activities to provide natural care through its members, privileging welcoming and attentive listening, accessible even as a domestic practice, such as by guiding how to use teas, homemade herbs gardens, massage and self-massage, foot baths, exercise, and food education to promote self-care (MACHADO, 2020; STOTZ, 2005).

MOPS consolidated its trajectory by organizing itself through the *Articulação Nacional de Saúde* [National Health Organization] in 1991, which was legitimated in 2003 as *Articulação Nacional de Movimentos e Práticas de Educação Popular e Saúde* (ANEPS) [National Organization of Popular Practices and Education in Health]. In 2009, the establishment of the *Comitê Nacional de Educação Popular em Saúde* (CNEPS) [National Committee for Popular Education in Health], and in 2012 the *Política Nacional de Educação Popular em Saúde* (PNEPS SUS) [National Policy of Popular Education in Health], strengthened MOPS even more, which was expanded by encouraging the establishment of units throughout Brazil (BRASIL, 2014; SANTOS, 2009).

MOPS units spread across the country, reaching Peruíbe in November 2017, through a partnership with the city government and a representative of the National Health Council, ANEPS, and the thermal complex's director. Thus, the

complex started integrating MOPS, which supplied a team of volunteers willing to provide CIP in its facilities.

This paper's objective is to describe in detail how the city's CIP policy was implemented, analyzing challenges and advancements, based on NPCIP documents and municipal policy on CIP (PERUIBE, 2018), along with the reports of those involved recorded on a field diary, and participant observation to describe the actions that led to its consolidation.

Material and Methods

This paper is an excerpt of a doctoral dissertation (CAAE 60508616.8.0000.5505//01/12/2016), the objective of which was to study the meanings assigned to the relationship between suffering and pain among individuals with chronic pain receiving Acupuncture and Therapeutic Touch treatment. The study setting was the CIP referral unit located in the city of Peruíbe, SP, Brazil. This referral unit resulted from a partnership between the City Health Department and a MOPS team and was approved by the municipal policy on CIP (MPCIP).

This study's objective was to analyze part of the ethnographic study that met a doctoral program's requirements. It is based on participant observation of meetings held from March 2018 to November 2019 with health workers and managers involved in the CIP implementation in Peruíbe. The analysis supported by field diaries focused on the MOPS involvement and discussions between the primary actors. This analysis was intended to understand how this policy was implemented in the city, emphasizing the main difficulties challenging its consolidation.

This study's object of analysis included the ethnographic study itself, the NPCIP and CIP documents published by the Ministry of Health, guidelines provided by the World Health Organization (WHO), and the city's legislation concerning Complementary and Integrative Practices.

Results and Discussion

The relationship between the CIP National and Municipal policies

The NPCIP implementation process in Brazil went through a long trajectory before it was consolidated and met the WHO's global guidelines. This global orientation roots back 50 years ago, when the world witnessed social upheavals, especially in

third-world countries facing scarce resources and a lack of health policies directed to vulnerable populations, which demanded a paradigm shift in the health care field.

The international conference on Primary Health Care, Alma-Ata in 1978, resulted in the Alma-Ata Declaration, calling for immediate worldwide action “to promote the health of all.” (BRASIL,1979). An extremely relevant factor was the recognition of workers providing Alternative Medicine (AM) or Complementary and Alternative Medicine (CAM), as healthcare providers. These practices were recommended to be included in public health services given their importance in the care provided to populations and recognition of the relevance of traditional knowledge (BRASIL, 2009).

At the end of the 1970s, the WHO launched the Traditional Medicine Strategy 2002-2005 (WHO, 2002) based on a Program on Traditional Medicine to encourage research and implement public policies intended to promote and motivate AM and CAM's implementation among its member countries.

At the time, there were isolated experiences in Brazil involving autonomous groups working in poor communities and providing popular education, encouraging people to retrieve traditional knowledge, and promoting education in health, hygiene, and diet (BRASIL, 2014).

In the 1980s, public health services started implementing Social Thermalism, Homeopathy, Phytotherapy, Acupuncture, and some mental health practices, which came to be supported by Resolutions of the Inter-ministerial Planning Commission and Coordination (Ciplan) – No. 4 to 8, March 1988. These resolutions set out treatment guidelines involving Homeopathy, Acupuncture, Thermalism, Alternative Mental Health Techniques, and Phytotherapy (BRASIL, 2011, 2015).

Concomitantly with the ongoing process within SUS, there were already many relevant social actions and demands for CIP to be implemented in the Brazilian public health service. The 8th National Health Conference held in 1986 (BRASIL 1986), a historical landmark in Brazil, listed necessary structural and procedural changes in the health field under the Health Reform Movement's strong influence. The 8th Conference final report proposed introducing alternative health care practices within the scope of public health services, with democratic access to therapeutic options.

Many relevant actions were promoted between 1985 and 2004, emphasizing homeopathic care in the public health network and establishing a technical team specifically for providing unconventional medical treatments. These were

recommendations provided by the 8th and 12th National Health Conferences providing on the incorporation of alternative therapies and popular practices within SUS, including phytotherapeutic and homeopathic medicines, and studies to develop a PHC national public policy (BRASIL, 2011, 2015; FIGUEIREDO; GURGEL; GURGEL JR, 2014).

The NPCIP text was developed and sent to a Tripartite Commission and National Council of Health for assessment. The Ministry of Health published it in 2006 in the form of decree 971(BRASIL, 2006) and in November of the same year, the Ministerial Ordinance SAS No. 853 was published. It included Complementary and integrative Practices (Code 068) in the Service/Classification Table of the National Health Care Registry (SCNES), SUS information system, giving not only visibility to SUS practices but also facilitating monitoring and assessment.(DE SIMONI; BENEVIDES; BARROS, 2009; BRASIL, 2006) Since these Ordinances were published, data from the Ministry of Health (BRASIL, 2011, 2015, 2018) show the population approves CIP and the expansion of these services to a larger number of cities, which resulted in recognition of CIP by two subsequent Ordinances.

In March 2017, Ordinance 849 (BRASIL, 2017) was approved, including other 14 CIP: Art Therapy, Ayurveda, Biodance, Circular Dance, Meditation, Music Therapy, Naturopathy, Osteopathy, Chiropractic, Reflexotherapy, Reiki, Shantala, Integrative Community Therapy, and Yoga, totaling 19 practices since March 2017. In March 2018 (BRASIL, 2018) Ordinance 702 was approved, further expanding the offer of these services, and making new categories of coverage more flexible, including another ten practices: Aromatherapy, Apitherapy, Bioenergetics, Family Constellation, Chromotherapy, Geotherapy, Hypnotherapy, Laying on hands, Anthroposophical medicine/anthroposophy applied to health, ozone therapy, floral therapy, and Social Thermalism/Crenotherapy.

The establishment of MPCIP in Peruíbe was aligned with the larger movement ongoing in Brazil so that Law 3587/2018 was implemented according to Ordinance MS-SUS 971, which was later expanded by Ordinances 849 and 702. These Ordinances defined the modalities and respective descriptions. Similar to the NPCIP, the CIP policy in Peruíbe was based on the “integrality of SUS actions and services and the single paragraph of article 3rd of Law No. 8.080/90, concerning actions intended to ensure physical, mental, and social wellbeing of people and the collective,

as determinant and conditioning factors of health”, as published in its original version in the city’s Official Bulletin No. 774, in April 3rd, 2018 (PERUIBE, 2018).

The purposes of the law recently updated include the progressive inclusion of CIP at all healthcare levels, ample access to the population, quality, effectiveness, and safety, the promotion of educational actions to train, qualify and update theoretical knowledge of the health workers in the local SUS units, and investments to meet referrals and spontaneous demand, establishing the black mud complex as a referral center.

Peruíbe’s vocation for health tourism facilitated the MPCIP implementation in the city, led by the medical director already known for his work with black mud and practice in Social Thermalism, Chinese Medicine, and Phytotherapy. For the same reasons, the City Health Council, the partnership established with MOPS, and consent by the Secretary of Health at the time, also supported the MPCIP implementation. All these factors granted support from the mayor and approval by the City Council.

When comparing the national and municipal policies, we initially analyzed the difficulties imposed on the NPCIP’s ample implementation and expansion in Brazil. Obstacles include the absence of a provisionary budget, insufficient coverage due to a lack of guidelines regarding actions and resources, lack of indicators to assess accumulated experience, unfamiliarity on the part of workers and managers, a lack of “confidence” in a model that diverges from the culturally established biomedical system, restricted or inexistent investment in mapping trained and qualified workers, and problems to rearrange the services’ operational methods to include the provision of CIP (OLIVEIRA, 2019; AMADO et al., 2018; LOSSO; FREITAS, 2017; MÜLLER, 2016; CONTATORE et al., 2015; LIMA; SILVA; TESSER, 2014; SANTOS, 2010).

Adherence to NPCIP on the part of cities, which depends on political will and managers’ discretionary power, may be hindered due to a lack of knowledge, discredit, or resistance to the model, resulting in the cities lacking interest in constituting such a policy.

The managers’ and workers’ unfamiliarity with CIP is a preponderant factor in refusing these practices. Claims include low quality, empiricism, no scientific proof, doubtful results, and even CIP having a placebo effect. Moreover, the few qualified workers and lack of professional training investment favor discredit, if not toward

traditional complex medical systems such as Traditional Chinese Medicine, toward the remaining therapeutic options devoid of a body of knowledge confirming the safety, scientific nature, and quality of treatments (BARROS et al., 2020; TESSER; SOUSA; NASCIMENTO, 2018; TESSER, 2018; SOUSA et al., 2012).

Even though MPCIP was officially implemented in Peruíbe, it faces similar obstacles in its consolidation. Based on data and the authors analyzed, the reasons for such an impasse concerning its consolidation in political terms may reside in two fundamental aspects:

1. The initiative came from the doctor in charge of the black mud project. He adapted Ordinance 971/06 for the city, seeking support from city councilors and from the Secretary of Health, who, in turn, sensitized the mayor. The Health Council was approached to request support from the Chamber and the MOPS to assemble a team.

According to Losso and Freitas (2017), and Santos (2010), there was no planning or discussions concerning its feasibility or social participation in the process. Nagai and Queiroz (2005) note the limitations imposed by a simplified decision based on a biomedical view of offering mechanistic techniques without modifying the model in which practices would be provided or adapting it to the health practice settings. A group was not chosen for developing the proposal or making a situational analysis, which according to Santos and Tesser (2012), should precede the regulation and implementation of policies. This MPCIP consolidation process reveals a top-down approach, in which only a few actors were involved in the implementation of this policy (SANTOS, 2010). Additionally, there was restricted content regarding institutional fragility and no dissemination or support from workers, services, and society, leaving a gap between the legislation and the practice context.

2. The Referral Unit joined the black mud project, maintaining the physician in charge for the project as the director (in addition to his other responsibilities as a public service physician), and was aligned with MOPS to support its feasibility. The Health Department did not allocate enough human resources, not through collaboration between two or more teams to create a pedagogical-therapeutic intervention¹, or by training or hiring new workers (TESSER; SOUSA; NASCIMENTO, 2018; TESSER, 2018). The facility, which already presented an inadequate structure and a lack of equipment, was not renovated, or adapted. The legislation (PERUIBE, 2018) dealing with personnel provision and training has not been fulfilled thus far, showing

a paradoxical inconsistency. The lack of human resources is aggravated because the medical director is on the city's staff and occupies various functions in other facilities, working as an acupuncturist only one day a week. A psychologist from the public network works in the unit as a volunteer only on Saturdays, out of her working hours. The lack of workers compromises the inclusion of these practices at all healthcare levels and PHC structures, as well as access to services and problem-solving capacity.

The difficulties concerning the lack of workers within the unit do not include essential aspects concerning the direction of NPCIP. According to Losso and Freitas (2017), its implementation should provide for the service considering four dimensions: care delivery (services), human resources, material resources, and management, implying dynamic actions, investments, training/permanent education, and coverage for the service to be classified as incipient implementation, partially implementation, or fully implemented.

Muller (2016) addresses 11 guidelines recommended by NPCIP, highlighting the importance of financing mechanisms, professional qualification, and human resources investment. Tesser (2018), Tesser, Souza and Nascimento (2018), and Santos and Tesser (2012) also report the small availability of qualified human resources, underfunding, and few facilities to provide new practices and services.

Therefore, underreporting of data in the system, considering the service is not properly incorporated into the official structure, results in a gap between what is implemented in practice and what is reported, compromising, even more, the transfer of funds intended to promote the implementation of CIP within SUS (SOUSA et al., 2012).

The MPCIP implementation process: actors, narratives, and facts observed

The black mud thermal complex in Peruíbe, constructed in 2004, started providing care to the population via SUS through its integration into the city's health network. Therefore, it became the first Social Thermalism unit linked to NPCIP, Ministry of Health, providing care according to demands and referrals.

In November 2017, the establishment of the MOPS-Peruíbe was initiated, to which the complex' director was integrated. With this approximation, there was a partnership proposal with the Health Department to provide care to patients referred by the public network; these were the actors responsible for the project. As MPCIP

determined, the black mud complex became a referral unit. This involvement with the Health Department and MOPS, reinforced by the city's Health Council, directly impacted the city's CIP public policy approval.

The complex's director gathered with a nurse from the Health Department and MOPS members to establish the CIP unit's logistics, planning, input supply, agenda, publicity, referrals, and services that would be provided. However, on April 13th, 2018, the negotiations were increasingly centralized between the complex's director and the MOPS team, with increasing distance from the mayor and his representatives, which was translated into a lack of access to medical records, to the SUS database or discussions regarding patients, and important sign of the complex's invisibility.

The service was initiated with MOPS volunteers who were willing to provide Acupuncture, Reiki, Therapeutic touch, Reflexology, Ayurveda-based Food Reeducation, and Family Constellation, with the possibility to implement a Meditation group. However, the health manager made no efforts to connect it to the PHC network to generate referrals. Thus, services were provided to spontaneous demand only, restricted to those who had the knowledge of and approved CIP.

Meanwhile, the secretary had been exonerated due to internal political issues, and the complex's director took a two-month leave to dedicate himself to studies, giving total freedom and discretionary power to the volunteers to make decisions regarding the service, without any supervision or interest on the part of the Health Department.

For months, the contact with the Health Department had been restricted to the director, when summoned. During this period, only once a director of the PHC visited the service. He had just taken office in the management change and was unaware of the complex and black mud project, NPCIP/MPCIP, or the partnership with MOPS. The reason for his visit was that he learned about the facility's poor conditions and the need for resource provision, for establishing a connection between the Health Department and health units, and the context involved in the implementation of a municipal public policy.

The reports gathered and facts observed during the study indicate some meanings managers held regarding CIP. These meanings show a subtle ideological clash between an affirmation of the biomedical paradigm, on the one hand, and the CIP's invisibility, on the other hand. Müller (2016), Tesser and Sousa (2012), and Tesser (2009) mentioned this invisibility when CIP were delegitimized due to discredit and distrust toward a vitalist, non-biomedical, and anti-hegemonic paradigm.

Following are some of the managers' reports, highlighted in two meetings and which reinforce the challenges listed by the authors previously mentioned:

MOPS is welcome to integrate the team and help the unit function, as long as they exclude care practices that include popular knowledge. Some may think it is “Macumba” [religious cult of African origin] and negatively impact the predominantly Evangelical community. (Field diary, March 2018)

Reports to this sort of restrictions to CIP were collected on other occasions, revealing a tension between the already established biomedical system and unconventional treatments based on popular knowledge and non-linear operating principles that encompass the entire context of health care delivery.(BARROS et al., 2020; OLIVEIRA, 2019; AMADO et al., 2018; TESSER; SOUSA; NASCIMENTO, 2018; MÜLLER, 2016; CONTATORE et al., 2015; BRASIL, 2015; LIMA; SILVA; TESSER, 2014; SANTOS and TESSER, 2012; ANDRADE and COSTA, 2010; TESSER, 2009; DE SIMONI; BENEVIDES; BARROS, 2008; BARROS, 2006).

The narrative presented here refers to the concept of invisibility, discredit, and delegitimation, not to mention preconception toward other types of knowledge and unfamiliarity with NPCIP and the WHO recommendations, already reported and reinforced by Tesser, Sousa and Nascimento (2018), Tesser and Souza (2012) and Tesser (2009). These authors stress the non-acceptance and devaluation of a “non-scientific” system compared to the model established by the dominant economic and political power, with rooted cultural and scientific beliefs.

Langdon (2014) explains that the predominant doctor-centered model distances itself from the understanding that health and disease are linked to an anthropological perspective, highlighting the importance of intermediality to approximate different healing systems and consider new forms of care delivery. Tesser, Sousa and Nascimento (2018) also note that the traditional knowledge of indigenous and African matrices are absent in the NPCIP itself.

Another manager visiting the facility stated:

I've never been here, didn't even knew this facility [...] Black Mud, Thermalism? [...] CIP municipal policy? [...] How come there is no employee in the team? What is MOPS? Are these people graduated? [...] I'm not familiar with these practices, don't understand any of this, but I do know what belongs to the medical field, because I was treated with acupuncture by a specialist colleague [...] I have no knowledge of professionals working with these practices in the Network, I'll check [...] I didn't know you had no material resources, but there's no budget provision [...] (Field diary, August 2018).

These reports indicate aspects that seem to hinder the full implementation of MPCIP in Peruíbe, including lack of managers' interest, unfamiliarity or lack of involvement with the public policy, the idea of care delivery based on a technical-bureaucratic model, depersonalization of care, unavailability of quality structured service, and not acknowledging the government's responsibility. All these factors had been already mentioned by Oliveira (2019), Losso and Freitas (2017), Müller (2016), Figueiredo, Gurgel and Gurgel Jr (2014), Santos (2010), De Simoni, Benevides and Barros(2008), and Nagai and Queiroz (2005).

Final considerations

The analysis shows that the process in which MPCIP was implemented in Peruíbe still has a long way to be fully consolidated within SUS, as recommended by the WHO and NPCIP.

The fact that CIP are not mandatory and depend on managers seems to be the initial obstacle impeding their consolidation. Another obstacle is that knowledge regarding NPCIP remains very restricted, coupled with the fact that the health system and the population have long recognized biomedical knowledge. These obstacles reveal a scenario of political disputes at the base of the CIP implementation and consolidation in the city.

Consolidation of what WHO (2002) and NPCIP (2006) recommend regarding humanized, continuous, and integral care is challenged by a context in which the biomedical model predominates as the reference for health services, professional practice, and the population in general. The hegemony of this model, therefore, acts as a resistance to a necessary paradigm shift, for the incorporation of other healing practices, according to different traditions, such as Traditional Chinese Medicine, Ayurveda Medicine and remaining practices with their conceptions and complex interventions, based on a holistic and integral view of human beings (ALVES; XAVIER JR, SÁ E BARROS, 2018), differently from what is proposed in the biomedical model.

If, on the one hand, Ordinance 971/06 validated medical practices that were already provided by health services, valuing complex medical knowledge such as Homeopathy, Phytotherapy, and Traditional Chinese Medicine, on the other hand, other care models, listed in Ordinances 702/17 and 849/18, bumped into

issues concerning scientific acknowledgment and the effectiveness of professional practice in therapeutic actions.

The challenges imposed to the implementation of MPCIP in Peruíbe seem to be related to forms of power rooted in the care system and centered on a way of doing health based on the biomedical model and legitimated by society. Society assigns this care model an unquestionable condition, considering it a reference of quality and safety, either due to its historical condition or social imposition that determines health care's cultural meanings.

This study's results reveal a top-down policy (SANTOS, 2010), implemented while disregarding the city's context, disconnected from the health policy instituted at the time, and even worse, not understanding the importance of horizontal communication during the process, revealing a lack of knowledge regarding the structural meaning of introducing a diversified and challenging care model to change the health system itself, according to the principles of humanized, continuous and integral care.

The considerations mentioned above seem to support the reasons for the delay in carrying out actions, including the purchase and maintenance of services, a lack of cooperation from the Health Department, no operational or systematization planning of communication, identification of patients, patient flow, or patient referral, no investment in hiring workers, no support or training to compose an appropriate team, and not returning to society a quality service aggregated to the healthcare service.

Despite the obstacles, tensions, and difficulties in the game of forces exposed in the MPCIP implementation in Peruíbe, some positive factors emerged during this process and should be highlighted. For instance, a care model that shifts the axis of attention from the disease to health, from physician to patient, considering the voice of those in distress by using attentive and welcoming listening, adopting more accessible language to facilitate understanding, and shortening the distance between workers and patients. Thus, the establishment of MPCIP represents an important and significant advancement, which is translated into possibilities to provide quality service in addition to many possibilities to implement complementary and integrative practices fully.

There was an attempt to resolve political disputes and obstacles to implementing the policy in the city, evidently not without tension. Note the City Health Department

contacted the remaining health departments and sectors to integrate and expand the activities, especially the communication service. Realigning the Municipal Health Council and society to problematize the issue and jointly seek solutions and implement measures with the Legislative and Executive powers was also relevant.

Measures to strengthen CIP with PHC and SUS include: focusing on more horizontal processes, such as valuing partnerships, like the one established with MOPS, and Popular Education interventions, the creation of medicinal herbal gardens, resuming consultations using traditional knowledge, expanding the services to ensure coverage among areas without CIP, promoting public campaigns together with community health agents, and working with schools and popular centers.

More importantly, the hegemonic biomedical model needs to be questioned, certainly within a potential dialogue between different types of knowledge and practices, according to an intermediality notion (LANGDON, 2014), to approximate diverse healing systems, “carriers of their own medical reasoning and therapeutic efficacy, consistent with their style of thinking, contradicting common sense that only biomedicine would carry rationality.” (TESSER, LUZ, 2008, p.196)

Given its innovative types of knowledge, practices, and relationships, the CIP-based care model raises doubts concerning the hegemony of the biomedical model, meeting health demands with quality service according to the assumptions endorsed by the World Health Organization and embraced by the Ministry of Health, to strengthen the SUS.²

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Notes

¹ “Matriciamento” in Portuguese.

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Resumo

Acompanhamento da implantação de uma Política Municipal de Práticas Integrativas e Complementares: principais desafios

Este artigo é fruto de um recorte da pesquisa etnográfica de doutorado realizada em uma Unidade de Referência em Práticas Integrativas e Complementares em Saúde (PICS), no município de Peruíbe-SP. A abordagem centra-se na análise da implantação da Política Pública Municipal de PICS (PMPIC), possibilitada pela observação participante de reuniões com profissionais e gestores, registradas em diários de campo, leitura de documentos do Ministério da Saúde e Organização Mundial da Saúde e do próprio texto da lei, bem como das narrativas dos atores envolvidos. A análise do material baseou-se na interpretação de base hermenêutica (GEERTZ, 1989), sendo apontados os principais desafios observados durante o acompanhamento do processo. O formato da PMPIC em Peruíbe, embora atenda ao recomendado em nível nacional e internacional, garantiu somente os aspectos jurídico-institucionais. Apesar do avanço na construção da política, os desafios para sua implementação e ampliação esbarram em dificuldades políticas e operacionais, que deverão ser superadas para o estabelecimento de amplas perspectivas para as práticas integrativas e complementares nos serviços de saúde do município.

► **Palavras-chave:** Práticas integrativas e complementares; terapias complementares; etnografia; Sistema Único de Saúde; política de saúde.

