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# Integrative and complementary practices in the health field: towards a decolonization of knowledge and practices

## As práticas integrativas e complementares no campo da saúde: para uma descolonização dos saberes e práticas


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## Abstract

This essay contributes to the dialogue between the approaches of Epistemologies of the South and the health field, focusing on the relationship between biomedicine and traditional, complementary and integrative knowledge and practices. Such relations are explored by using dimensions of knowledge, power and the self, based on the perspective of decolonization. This is a theorical-conceptual study. The **decolonization of knowledge** aims to decolonize science and appropriate it in an anti-hegemonic manner to value interculturality, enabling the inclusion of different types of knowledge and care practices. The **decolonization of power** presupposes equality in the face of free access while performing different types of therapeutic resources, not considered as marginal forms of treatment. The **decolonization of the self** incorporates therapeutic practices in subjective areas, such as religiosity/spirituality and the arts, which are necessary to a whole conception of the person. Ecologies of knowledges emerge from the encounters and articulations of these dimensions, as a pathway for decolonization in health. The public health field has a central role in this process, but its conception of health must be broadened by incorporating diversity and plurality of knowledges and social practices.



**Keywords:** Epistemology; Decolonization; Public Health; Complementary Therapies; Interculturality.



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## Resumo

O manuscrito, em forma de ensaio, objetiva contribuir para o diálogo entre as abordagens das Epistemologias do Sul e o campo da saúde, com ênfase nas relações entre a biomedicina e os saberes e práticas tradicionais, complementares e integrativos. Essas relações são exploradas a partir da produção do conhecimento sobre as dimensões do saber, do poder e do ser na perspectiva da descolonização. Estudo de natureza teórico-conceitual. A **descolonização do saber** procura descolonizar a ciência e apropriar-se dela de forma contra-hegemônica, valorizar a interculturalidade, abrindo espaços para a inclusão dos diferentes tipos de saberes e práticas de cuidado. A **descolonização do poder** supõe a igualdade frente ao livre acesso e exercício dos diferentes tipos de recursos terapêuticos, deixando de tratá-los de forma marginal. A **descolonização do ser** incorpora práticas terapêuticas no campo da subjetividade, como a religiosidade/espiritualidade e as artes, sendo necessárias para a completude da pessoa. Dos encontros e articulações dessas dimensões emergem ecologias de saberes, abrindo o caminho à descolonização na saúde. O campo da saúde pública tem um papel central a desempenhar nesse processo, mas falta ampliar a sua concepção de saúde, incorporando a sua diversidade e pluralidade de saberes e práticas sociais.

**Palavras-chave:** Epistemologia; Descolonização; Saúde Pública; Terapias Complementares; Interculturalidade.

## Introduction

This essay, is a contribution to the dialogue between postcolonial approaches – and, in particular, the Epistemologies of the South, having as its main reference the works of Boaventura de Sousa Santos and the research program initiated by him, and the health field, with emphasis on the relations between biomedicine as a space anchored in hegemonic knowledge and practices in health, on the one hand, and, on the other, the knowledges and practices usually gathered under the label of Traditional, Complementary and Integrative Medicines (TCIM), a term used by the World Health Organization (WHO) (OMS, 2013), known in Brazil as *Práticas Integrativas e Complementares em Saúde* (PICS–Integrative and Complementary Health Practices) (Brasil, 2006).

Such health practices have a long history in the Brazilian context, but it was only in 2006, with the approval by the Ministry of Health of the National Policy of Integrative and Complementary Practices (PNPIC), as part of the Brazilian Unified Health System (SUS), that this denomination became the most common one. The therapeutic systems and resources included in the PNPIC ranged from traditional Chinese medicine/acupuncture, homeopathy, the use of medicinal plants and phytotherapy, to anthroposophical medicine and social thermal/crenotherapy (Brasil, 2006).

In 2017 and 2018, PNPIC was expanded with the introduction of 24 new practices and therapeutic resources: art therapy, ayurveda, biodance, circular dance, meditation, music therapy, naturopathy, osteopathy, chiropractice, reflexology, reiki, shantala, integrative community therapy, yoga, apitherapy, aromatherapy, bioenergetics, family constellation, chromotherapy, mud therapy, hypnotherapy, laying on of hands, ozone therapy, and Bach flower remedies (Brasil, 2017a, 2017b, 2018). With the new practices, SUS now offers a total of 29 procedures to the population. However, it is worth mentioning that this expansion was not discussed with professionals and researchers in the area, and it did not create strategies aimed at welcoming the cultural diversity associated with these knowledges and practices within the country.

Even considering the progress that occurred with the implementation of this policy in the Brazilian public sphere, it is important to highlight that by failing to incorporate traditional indigenous medicine and the various ways of dealing with the health-disease process in black communities and populations from urban peripheral, countryside, water and forest regions, PNPIC perpetuates the historically persistent invisibility of these peoples' knowledges. Thus the hegemony of a form of knowledge/power associated with the historical persistence of traces of colonialism stands in the way of the recognition of the diversity of knowledges and practices in health by those who formulate and implement public policies.

We consider the variety of therapeutic systems and resources that constitute PICS within SUS. Their diversity is noteworthy; but beyond its recognition, this raises a challenge for research in health, since it includes practices that do not share the same cosmologies. For the purpose of this study, we propose to group them in order to identify those practices that, on the one hand, seek to break with the colonial character of biomedicine and its monoculture and, on the other hand, point to social, and plural practices that differ from each other, but which can be mutually recognized, respecting their specificity and relating in a complementary way (Guimarães et al., 2015). This process can be described as a step towards the **decolonization** of knowledges and practices.

The aim of this essay is thus to contribute to the dialogue between the Epistemologies of the South and the health field, signaling how the colonial dimension – by the weight of its historical heritage and the persistence of conceptions and practices that marginalize, invisibilize, appropriate or suppress non-hegemonic knowledges and practices – interferes with the relationship with PICS in public policies and cuts across the field of health, which is dominated by a tension between a process of biomedicalization of health and the process of Health Reform and the emergence of Collective Health in Brazil (Nunes, 2012). These relationships are explored through the dimensions of knowledge, power and the self, from the perspective of decolonization of knowledges and practices. The study has a theoretical-conceptual focus, based on a review of relevant literature and the authors' experience with the topic, as PICS professionals, managers, teachers and researchers, for more than 10 years. Thus, the essay begins with a synthesis of the topic based on the propositions of the Epistemologies of the South. The following sections include an analysis of, first, the colonization of knowledge in the scientific field and the possibility of opening up paths toward decolonization through its engagement with PICS, while seeking to value interculturality and the inclusion of different types of existing knowledges and care practices; secondly, the colonization of power, expressed by the medical-industrial complex, structured basically around the pharmaceutical industry and medical institutions, equipments and work, faced with the double claim of equality of access to biomedical resources and the free exercise of different types of therapeutic resources; and, finally, the colonization of the self, expressed by the construction of the biomedical subject and the monocultural understanding of the health/disease/care process.

## Epistemologies of the South and the decolonization of knowledge and practices

The Epistemologies of the South seek to explore how science relates to and engages with other forms of knowledge and experience, arguing that the "abyssal" cartographic lines, which in the colonial era separated metropolises from colonies, persist in forms of thinking and acting constitutive of political and cultural relations, which mark the division between territories or metropolitan areas, characterized by the tension between regulation and emancipation and the reference to the rule of law, and territories and areas where appropriation and violence are paramount (Santos, 2007). In this sense, the scientific thought of the modern period began to respond exclusively to the problems posed by science, which holds the monopoly of universal distinction between the true and the false. Moreover, scientific thought subjected the forms of knowing specific to philosophy, theology, humanities and

arts to a hierarchy of criteria of validation which defined them as lacking the rigor and validity of scientific knowledge. The situation of the kinds of knowledge located on the other side of the abyssal line became more critical, since they did not fit into any of the criteria defining knowledge, and thus were disqualified or declared as forms of ignorance, belief or superstition to be eradicated by science and its cognitive and instrumental reason. These kinds of knowledge came to be described as traditional, folk, peasant or indigenous knowledge (Santos, 2008). To make it short, the exclusion of knowledge imposed by modern science falls on everything that cannot be measured and/or evaluated by its criteria.

The proposal of another epistemology based on the experiences, knowledges and practices of the global South, according to Santos (2002), and the idea that the understanding of the world is not exhausted by Western understanding of the world is meant to enhance its visibility. The proposal of a post-abyssal thought associated with an ecology of knowledges is meant to recognize the dignity as well as the validity of all knowledges based their own criteria. According to Santos (2007) and Nunes (2008), it is a pragmatic epistemology, in which the evaluation of a certain knowledge should be carried out on the basis of its consequences or effects, considering its situated and contextual conditions of its production and use. The Epistemologies of the South consider how a given knowledge is born out of the experiences and struggles of the oppressed, or how it is appropriated and affects such experiences and struggles, as is the case of different types of scientific knowledge. This is a central criterion for the evaluation and validation of the knowledges and practices that underpin the emergence of ecologies of knowledges.

An ecology of knowledges implies a process of validating the contribution of the different kinds of knowledge in a given situation, The validity of each knowledge will depend on how the contextual and practical conditions of its production and validation (Nunes, 2008), how it is appropriated, reproduced and shared and how it deals with problems calling for an appropriate response to conditions of domination and oppression. This ecology aims not only to overcome the monoculture of scientific knowledge, but also to overcome the idea that non-scientific knowledge is alternative to scientific knowledge (Santos, 2002): "in the ecology of knowing the search for credibility for knowledge does not imply the discredit of scientific knowledge. It simply implies its counter-hegemonic use" (Santos, 2007, p. 26).

The concept of ecology of knowledges aims at contributing to the visibility of the different knowledges and practices that exist worldwide, but which are invisible, disqualified or suppressed (sociology of absences), and to the creation of forms of intelligibility and intercultural translation – the procedure that enables the creation of reciprocal intelligibility among the world's experiences. Translation work focuses on both knowledges and practices (and their agents). The aim is to restore visibility to existing epistemological diversity to expand the experiences of the present (sociology of emergencies). In some cases, when it is not possible to integrate the different knowledges and practices, those ensuring the participation of the social groups involved should be favored, so that a higher level of collaboration occurs (ecology of knowledges) (Santos, 2007).

Notably, one of the main inspirations of the Epistemologies of the South is the pedagogy championed by Paulo Freire (2011), the Brazilian educator who became a pioneer in the deconstruction of the colonial viewpoint by taking as a starting point the experience of the excluded and oppressed (Santos, 2018). Freire (2011) postulates the respect for all kinds of knowledge, understanding them in their differences. For the author, the construction of knowledge is not only built on science and technique, but involves dialogue and *amorosidade* – or what Santos (2019) describes as "warm reason", the inextricable relation between reason and affect –, being a continuous process that occurs in a shared manner.

The educational practices in health, based on Freire (2011), seek a dialogical and emancipatory approach, with a view to promote the subjects' autonomy, valuing the knowledge of the other, based on the understanding that knowledge is a process of collective construction.

In the **Freirean** thought, autonomy and respect for different cultures and traditions are necessary for

the emancipation processes, as it is also postulated by the Epistemologies of the South. However, by drawing attention to the issue of *amorosidade*, Freire (2011) seeks to highlight a less valued aspect – often dismissed by scientific knowledge, but essential to the possibility of respect and dialogue between different cultures. What Freire calls *amorosidade* is even more central in the health field, as a condition of inclusion and recognition of difference.

## Colonialism/decolonization of knowledge

**Colonial knowledge** is based on the hegemony of a specific kind of knowledge, represented by Eurocentric scientific knowledge which affirms as its central criterion the universal distinction between the true and the false. The knowledge of modern science is therefore identified with the truth, and it subordinates other kinds of knowledge to its logic of domination, delegitimizing them, and asserting the idea of a possible and necessary neutrality of knowledge – epistemic, philosophical and scientific – along a hegemonic single-path (Quijano, 2005; Santos, 2008, 2018).

The consequence is the exclusion of all kinds of knowledge that cannot be measured and/or assessed by current scientific criteria. The knowledges of the humanities, such as those of philosophy and theology, are also subjected to a hierarchy dominated by the criteria of validity defined by science. Existential problems are thus excluded from the range of topics recognized as scientific, unless they can be reduced to the processes recognized as relevant by a naturalistic approach. Finally, the various forms of lay, folk, indigenous, and common-sense knowledge become invisible or subordinate (Santos, 2008).

The **decolonization of knowledge** seeks to expose the colonial foundations of Eurocentric, modern science and open up the possibility of it being appropriated in a non-hegemonic manner. It proposes to work through possible connections of different modes of knowing towards ecologies of knowledges (Santos, 2007; Martins; Benzaquen, 2017).

When considering the **colonial traces of knowledge** in the health field, one soon perceives its hierarchies of power and modes of functioning in the very asymmetry present in the denomination of the various health care practices, such as the uses of the terms "alternative," "complementary" or even "traditional." The biomedical rationality of contemporary Western medicine may be regarded as a manifestation of these colonial traces of knowledge on the body, health and disease. Other health rationalities, such as homeopathic medicine, traditional Chinese medicine (Luz, 2012), indigenous medicines (Andrade; Sousa, 2016), and those with African roots (Garcia, 2016), among others, are marked in their difference by adjectives, thus defining them as belonging to specific configurations of knowledges and practices with conceptions of body, cure, health and disease differing from the hegemonic knowledge of biomedicalized health. Subjectivity, belief, magic and suggestion are some of the forms of naming the knowledges and practices that resist or exclude themselves from the scientific criteria of biomedicine. Its recognition and validation presuppose their subordination to these criteria, without meeting the implications of the differences in world, body, subject, and conceptions of health/disease and care (Guimarães et al., 2015).

Integrative and complementary health practices in Brazil, especially when considering the complex systems that involve them, have, as one of their characteristics, integrality (Sousa; Hortale; Bordstein, 2018), which demands an expanded view of people's health needs. That is, the response to health problems must integrate its various dimensions – physical, psychic, social, spiritual – to escape the reductionism imposed by the biomedical viewpoint. Based on colonial epistemology, which tends to consider only the biological/physical and acute aspects of illness, tending to reduce the subject to object, and to the fragmentation of the human body by different medical specialties, with a strong emphasis, in more recent periods, in genetic and genomic studies. The association between types of knowledge, clinical practice, technological and pharmacological resources, forms of organization, financing, regulation, professionalization and work that characterizes biomedicine contributed

to impersonality in the health professional-patient relationship and the consequent suspension of intersubjective relations in the process of health care (Clarke et al., 2010; Gaudillière, 2006; Lock; Nguyen, 2010; Nunes, 2012).

Biomedical knowledge, as the only kind of knowledge setting the standards of practice in the health area, became the model to be followed, the only kind of knowledge allegedly capable of solving the problems of the health-disease process and to accurately define is relevant to the health field. The ability to recognize the status of health or disease thus becomes limited to medical discourse and practice. One of the consequences is that the subject's competence to account for their own experience is dismissed. The subject's speech is relevant only to provide clues for medical diagnosis (Guimarães et al., 2014), or, in psychiatry, as a symptom of the disorder or disease.

These factors have led to a progressive loss of subjects' autonomy to deal with issues related to diseases and their treatments, in an increasing process of dependence on the population towards drugs and prescriptions of institutionalized medicine. According to different authors, health corresponds to the degree of autonomy that enables the person to exercise control of their own biological status and the immediate conditions of their environment, i.e., health is identical to the degree of freedom experienced (Illich, 1975). Encouraging the subject of therapy to associate their disease with a process of knowledge of themselves, however, amounts to encouraging and sustaining a critical and liberating knowledge, even if it may seem to lack relevance to hegemonic knowledge and practice.

The hegemony of biomedicine has been debated, to the extent that it does not always address the problems presented by the population (Luz, 1997). While treating the body as a machine, biomedicine separated it from soul and emotions, focusing on the symptoms of isolated and specific parts of the physical body, dehumanizing care and thus encouraging patients to search other forms of comprehensive health care (Luz, 1997). The often invasive character of biomedical interventions and the iatrogenic effects of medication and therapies are additional motives for that search (Chan, 2008).

Interest in the study of the potential of TCIM is thus currently growing, as well as the search for these types of therapies worldwide. The increase in demand can be related to the fact that many of these TCIM are less invasive, less expensive and less medicine-based than biomedicine (Brasil, 2006; Sousa et al., 2012, Tesser, 2006). Many of the practices included in TCIM promote actions that stimulate the potentials of healing and rebalancing of subjects in search of self-knowledge, prevention and promotion of health. Many TCIM contribute largely to the treatment of chronic and degenerative diseases, a high point of current health care, and of particular interest when addressing issues of care of an aging population (Tesser, 2009).

In addition to these problems, we are witnessing an increase in diffuse suffering – an epidemiological label for what psychiatry has called common mental disorders –, malaise related to the expressions of illness, manifesting itself by a diversity of symptoms, such as irritability, insomnia, anxiety, nervousness, anguish, body pain, related to the emergence of several diseases, for which the therapeutic system of biomedicine does not have adequate resources, thus tending to prescribe psychotropic drugs to the people who display these symptoms (Lacerda et al., 2007). The use of drugs does not respond adequately to these situations, and sometimes it becomes itself a source of chronicity, generating dependence on this type of medication and covering up the discussion of socioeconomic issues related to the causes of the suffering and of the formulation of health practices and policies that meet the needs of the population (Fonseca; Guimarães; Vasconcelos, 2008; Lacerda et al., 2007).

Several integrative therapeutic practices may contribute to responses to suffering which avoid or limit the processes of social medicalization and the indiscriminate use of technologies, by relocating the suffering subject, not the disease, at the center of health care. Thus, they relocate the relationship between therapist and patient as a crucial element of therapy (Tesser, 2006).

This is the case, for example, of Integrative Community Therapy (ICT), a therapeutic resource to work with groups, developed in Brazil for more than 30 years, and included in the PNPIC. Through this

technique, performed in a talking circle, seeking to share life experiences and wisdoms from listening to the stories that are reported there, all participants become co-responsible for the search for responses to the everyday challenges of life that affect health and well-being. It seeks to welcome and resignify suffering, originating a new reading that turns it into growth. The recovery of self-esteem is sought as a crucial resource (Barreto, 2005).

According to this author, the community therapist is a facilitator of the group process, seeking to work on people's competence to enhance and value the knowledge produced by the experience of the other, according to the cultural codes of the group in question. ICT seeks personal transformation based on the discovery of the potential that each one presents to solve the problems. Based on life experiences, and when it is related to scientific and other forms of knowledge, the subjects produce new configurations of knowledges based on shared experiences (Guimarães; Valla, 2009).

It can be said that ICT is a facilitating approach to self-empowerment, since it enhances individual and collective resources, to the extent that the group appropriates the qualities and forces that actively exist in social relations. Therefore it aims to be an instrument for the construction of social support networks (Barreto, 2005), to the extent that people become more resistant to illness, knowing that they will get continuous emotional support and solidarity from the group (Guimarães; Valla, 2009).

The knowledges that resonate with the perspective of decolonizing of knowledge are those that recognize the needs of each patient and having the ability to mobilize the procedures and technologies pertinent to each case (Mattos, 2004). Therefore, the implementation of an integral system does not occur exclusively by applying existing disciplinary knowledge, but by the construction of effective practices (Pinheiro; Luz, 2003), with a plurality of dimensions and with a view not only to technical success, but to achieving a practical success appropriate to the situation and the problem at hand. Thus, as suggested by the ecology of knowledges, the validity of each knowledge will depend on how it is linked to the practical conditions of its production, validation and effectiveness (Nunes, 2008).

It is important to emphasize that such systems and therapeutic resources are not presented as a single path or way, but as a possibility to expand health care. All the technical and scientific advances of biomedicine over time in relation in the treatments of diseases and the increase in the subjects' life expectancy cannot be denied. The fundamental issue is that many of the problems of the health-disease process faced by the population have not been raised by biomedicine and the latter has been lacking in appropriate responses. Examples of these problems are diffuse suffering, violence in its various forms and the chronicity of illness. This can be verified by to the extent to which most suffering does not match a biomedical nosography. Therefore, the need to change the focus. Health problems should be identified and accounted for by those who suffer, considering their diverse dimensions, beyond the scope of biomedicine. Other expanded looks are sought, covering, among multiple aspects, therapeutic itineraries, local care networks, such as family support, religious/spiritual, recreational and artistic groups.

Thus, an entire research space is opened up in the field of health to investigate the therapeutic resources drawn upon by the population – including PICS – which can contribute to the resolution of health problems. Decolonizing knowledge in the field of health means opening up these spaces for the inclusion of multiple and varied forms of existing health care experiences, resisting attempts at domination by any of them. Decolonizing health care requires that PICS and other counter-hegemonic forms of care be no more excluded or treated as marginal, recognizing their own criteria of validation. Post-abyssal knowledge in the field of health implies the creation of spaces of mutual recognition. The fundamental question that arises is how to create such spaces.

## Colonialism/decolonization of power

According to Quijano (2009), colonial/modern power consists of a complex matrix forming a mesh of social micro-relations of exploration/domination/

conflict articulated through the interconnection of racial formation, control of work, the State and the production of knowledge. From the perspective of this author, the inclusion of the category "race" in the classification of individuals in power relations – although its production and full incorporation is relatively recent, that is only 500 years old, – consists of the legitimizing reference fundamental to the Eurocentric power standard that dominates humanity. The dominant are those of "white race," the dominated belong to "races of color."

In the health field, colonial power is embedded in the medical-industrial complex, basically structured around the pharmaceutical industry and medical knowledge and equipment. This model hinders the access to other forms of health care that are not structured under the aegis of this complex. On the other hand, it has evolved into the specific blend of medical and biological knowledge and practice known as biomedicine, centered on hospital care, focusing on medical specialties and requiring intensive use of technologies and medication.

Despite the persistence of some remnants of a colonial bias thus understood, Primary Health Care (PHC) and the Family Health Strategy, through its focus on the territory, household and family, tend to set limits to the standardization of interventions and procedures, seeking to meet the needs of persons and communities. Thus, despite its basic reliance on the biomedical model, its performance is not focused on the hospital-centered approach to health. It includes promotion, prevention, care and rehabilitation aimed at persons, their families and community health. According to Tesser and Sousa (2012), several PICS are related to the proposal of PHC in some aspects, such as: the use of community resources of various kinds, seeking simpler, low-cost therapeutic means relying on "light" technologies; the search for natural healing and rebalancing mechanisms centered on the capacities of patients/users, which prove satisfying and effective from the viewpoint of their users. This explains why most (70%) PICS within SUS are provided by PHC (Brasil, 2006) and, internationally, PHC is the main "gateway" to PICS in national health systems. These experiences converge with efforts at the decolonization of power in the health field.

The **decolonization of power** starts from the recognition of the diversity and difference of cultures and cosmologies, their knowledges and practices. But it also requires the recognition of unequal relations, domination and oppression between different knowledges and cultures (Quijano, 2005; Santos, 2018). Brazil, due to its diversity, with its different ethnicities and communities, hosts a "cultural heritage matching that of any other country on the globe, but it faces enormous challenges to the enactment of recognition, legitimation and respect for diversity" (Barreto, 2011, p. 8). Drawing on this heritage for an ethics of care and appreciation of life and human potential is our challenge.

In the field of health care, decolonization of power presupposes the capability – considering the diversity of cultures, knowledge and practices aimed at care and healing – to respect their difference and integrity and, at the same time, work collaboratively and non-extractively towards the construction of configurations of knowledges oriented to the situated response to problems. This implies, on the one hand, finding ways to facilitate and to promote access to these different cultures of care and healing and their therapeutic resources, problematizing the hegemonic conceptions of knowledge and its validation. As these emerge as ecologies of knowledges and practices in health, citizens should have the right to choose the pathway that best suits their desires and struggles for health care and for cognitive and social justice.

Care as a right can be understood as more than the delivery of medicalized health or access to medical knowledge and technologies. It involves forms of meaning and action aimed at understanding health as the "right to be." This involves attention to differences between subjects – be they based on class, ethnicity, gender, sexual orientation, religion or subjectivity – as more than carriers of pathologies or disabilities, but also as striving to fulfill needs and desires (Pinheiro; Mattos, 2005). Therefore, thinking about the right to be is to guarantee access to other health rationalities and therapeutic practices, to other forms of care that value affections, emotions, desires and experiences, and which enable subjects to actively participate in the decisions regarding

their own therapeutic pathways (Guimarães et al., 2014).

Regarding PICS, the enactment of PNPIC represented a breakthrough in ensuring patients' right to access these practices, but neither an implementation plan nor a specific budget were foreseen to ensure that these practices would actually be offered, as well as the training of professionals. Public resources for health care are generally distributed and managed by institutions organized under the hegemonic rule of biomedicalized health. Without financial resources, little progress has been made over the last years. The implementation of these practices at the municipal level owes its viability and visibility to the efforts of committed managers, professionals and users (Guimarães et al., 2015). But even where the training of therapists in PICS has been achieved, it has mostly been designed as specialization courses of health professionals, subject to validation according to current practices and criteria within the domain of biomedicalized health.

There is much to be done to create spaces for emancipation, empowerment, social articulation and respect for the culture of different peoples, communities and groups, so that their traditions and health practices are recognized and valued as legitimate practices in the field of health. Participatory management, popular participation in health councils and organizations and services and social control are fundamental both to explore the openings emerging within the field of health and to mobilize and articulate the actors as they claim their right of access to and use of the whole range of therapeutic practices and traditions. This requires as well significant investment in the production, training and continuing education for health professionals as a condition for the recognition and enactment of cognitive justice for a broad, intercultural understanding of the right to health.

Horizontally woven social networks, enabling articulation, reflection and communication between participants, are one of the possible forms of popular participation for the strengthening of social actions and implementation of public policy. One example is the National Network of Social Actors in Integrative and Complementary Health Practices (RedePICS),[1] created during the 2nd Northeastern Meeting of PICS/Recife in 2015. Its mission is to integrate all social actors who work, investigate, teach and study to strengthen integrative practices as a public health policy, which includes knowledge production, training and assistance (Guimarães et al., 2015).

At this very moment, the possibilities of sustainable articulations involving actors in a dynamic and systematic way are on the agenda of RedePICS. The idea is to promote an emancipatory dynamic involving all participants in the network. The monitoring of the actions of the network has been carried out considering the capacity to mobilize and monitoring the information on actions, including indicators of supply, use, legal regulations and budget, as well as training and types of professionals' insertion of professionals.

One initiative which deserves special mention is the constitution of the *Red de Medicinas Tradicionales, Complementarias y Integrativas para las Americas*, which is managing the Virtual Health Library (VHL) of MTCI and associated database,[2] in charge of the Latin American and Caribbean Center on Health Sciences Information (Bireme), with the support of the Pan American Health Organization (PAHO) and WHO.

## Colonialism/decolonization of the self

The introduction of the dimension of the **self** from the perspective of decolonization of knowledge arose based on the reflection about the relationship between modernity and colonial experience. According to Maldonado-Torres (2009), modernity is related to time, while expansionism and land control are related to space. The concept of modernity hides how relevant spatiality is for the production of modern discourse, by adopting a universalist perspective. Europeans are considered modern, since the "discovered" lands, which have become colonies, are declared empty or uninhabited, without people, without owners (to the extent that the native

1 Available from: <https://bit.ly/2uWw55z>. Access on: February 21, 2020.

2 Available from: <mtci.bvsalud.org>. Access on: February 21, 2020.

people's culture does not have the understanding of what private property is), with no spiritual values, according to European thought; therefore, native peoples are deprived of "rationality" (Maldonado-Torres, 2009). Modernity has never existed, nor can it exist, without the colonial dimension that creates these non-being zones, to use Fanon's term.

Therefore, what Maldonado-Torres calls the **coloniality of the self – the various expressions of the colonial conception of the person and the self** – operates in subjectivity by the identities that fix and subdue: the European, the Aryan, the indigenous people, the black population, showing how power names and hierarchizes identities. Decolonization, on the other hand, seeks to value interculturality, allowing subjects to build and mutually recognize their identities according to their histories and experiences, and strengthen themselves in interlocution (Martins; Benzaquen, 2017).

We suggest this conception operates in the health field according to biomedical rationality. Biomedicine, based on materialistic/Cartesian thinking, is a knowledge that needs the visible, the concrete, with its means of measuring, predicting and estimating as tools for its validation. The primary focus is the disease as a physical entity at the expense of the subject who suffers with a disease. And the main goal is to control and eliminate the symptoms of diseases and, eventually, its underlying (biological) causes.

Individuals subject to this type of rationality construct their subjectivity and ways of dealing with the health-disease process based on these parameters. That is, the disease, identified as an injury of the physical/biological body, is not seen in relation to the organism as a whole and it is not related to a process of self-knowledge and search for autonomy, but is dependent on medical prescriptions, diagnostic tests, medications and surgical interventions, when necessary.

When presenting such characteristics of the biomedical model we do not intend to impose value judgments on it, but to identify certain characteristics gathered into an ideal type (in the **Weberian** sense of the term), to the extent that there are many and varied nuances, both in professional practice and in the modes of self-care. The same can be said when we compose the ideal type of health practices associated with what we may generally designate as a vitalist paradigm, including several PICS. We suggest that this paradigm has affinities with the perspective of **decolonization of the self** in the field of health.

The notion of vitalism encompasses different positions and currents, which have in common the reference to a vital principle or to a conception of life inseparable from the spirit, which governs the phenomena of life (Nascimento, 2012). By evoking phenomena that are not reducible to those that are observable through the technical-scientific apparatus sustaining the knowledge and actions of biomedicine, we intend to signal the possible opening of spaces for problematization of the postulates of biomedical knowledge and the limits they impose on the understanding of the health-disease-care process. Health is conceived holistically or as the result of the complex dynamics of heterogeneous forces and processes, varying its definition between convergent but not always coincident concepts, of harmony or balance between body and spirit and between the subject and their environment. The subjective dimension of human existence is valued (Nascimento, 2012). The drugs or procedures adopted aim to stimulate the potential for rebalancing one's own being, which necessarily includes a process of self-knowledge.

From a vitalist perspective, the disease is the result of an imbalance between natural and spiritual forces, understood as the disruption of harmony with the cosmic order in motion (Luz, 2012). The process of illness is presented as an opportunity for the organism to rebalance. Therefore, it is crucial to stimulate the active participation of the individuals in dealing with disease and in the process of self-knowledge.

This paradigm has been present in humanity since the Ancient era. Hippocrates (460 BC-380 BC), a Greek sage regarded as the "father of medicine," postulated the search for a knowledge of disease based on clinical observation. He considered the imbalance between what he called humors: blood, phlegm (state of mind), yellow bile and black bile as the cause of diseases. For Hippocrates, every body carried the elements allowing its recovery

from disease. But knowledge of the body would only be possible as part of self-knowledge as a whole. The self represented the microcosm and the universe the macrocosm. The microcosm should be in harmony with the macrocosm. The human body should be balanced with its external environment. In his study of "airs, waters and places," Hippocrates exposes the influences of the environment on human health, highlighting pure water and clean air as essential factors for a healthy life. It was only with modern science that the vitalist paradigm was undone.

In order to advance further towards the **decolonization of the self** in the field of health, other knowledges and practices of health care, associated with the vitalist perspective and considering its diversity, should be incorporated, such as the fields of religiosity/spirituality and the arts (Santos, 2018). Both appear as therapeutic practices, acting on subjectivity.

Guimarães (1996) points out that the religious/spiritual experience, besides producing change in the field of subjectivity, is itself a producer of meanings, when one understands experimentation as a central issue that articulates the ethical, cultural, religious, and political points of view. According to the author, the search for symbolic-religious practices is embedded, in most cases, in the search for self-knowledge.

The search for religion as a way to solve health problems has never ceased to be part of Brazilian society, and currently presents signs of growing. Despite the historical domination of Catholicism, there are a large number of Catholics in Brazil who turn to Spiritist centers, Umbanda and Candomblé yards and, more recently, Evangelical cults. However, for a long time, Afro-Brazilian religions could not be practiced in Brazil, due to prohibitions imposed by colonial power. Being syncretic religions, they were regarded with suspicion, and their followers were persecuted due to practices attributed to them, such as black magic, healing practices outside the scope of official medicine and other activities judged as sources of evil or perversion.

Umbanda, for example, is an eminently Brazilian religion, which gathers elements of heterogeneous and ethnically diverse origin. In the Umbandista conception, as well as in Kardecist spiritism, the disease – whether physical or spiritual – originates in the spirit. The physical body is just a receptacle or a ground wire; the spirit provides life to the body. Health is the harmony with the forces of nature. The onset of the disease is related to the disharmony of the person with their environment and/or with their own nature, that is, with their desires and deep feelings (Guimarães, 1996).

Mediumship is the quintessential spiritual experience in Umbanda. The body is seen as a "device" so that spiritual forces can express themselves, by incorporation or possession, psychography and other forms. It is through incorporation that religion materializes and updates. Possession refers to the radical change that occurs in people through trance, which represents the paradoxical tension of a person being themselves and, at the same time, being able to present themselves with many faces (Guimarães, 1996). Possession enables the individual to live multiple aspects of their personal identity and thus can be understood as a therapeutic spiritual experience. According to Augras (1983), trance is one of the moments that articulates the progressive construction of the adept's identity, as a singular individual and a support for the divinity. In the case of Umbanda, followers incorporate four main types of "entities" or "categories of spirits": *caboclo, preto-velho, criança* and *exu*.

The **decolonization of the self** also operates through the arts, to the extent that they are necessary for the completeness of the individual, as means of responding to their desires and to relate to the world. According to Fischer (1987), if the nature of the human being was restricted to being an individual, this would be absurd and incomprehensible, since every individual would already be complete, whole. The humans' desire to develop and complete themselves signal that every person is more than an individual. One can only achieve one's fullness when engaging with the experiences of other people who potentially concern everyone else. What a woman or a man feels as potentially hers or his involves everything that humanity as a whole is capable of. Art is the indispensable path for this union of person and

whole, for it opens up the virtually infinite human capacity for association, for the circulation and sharing of experiences and ideas.

Human beings need a propitious environment to develop their creative potential, where they may find the space to enhance their uniqueness and reintegrate it into relational reality through cultural, social and political activities. Therefore, this space is internal to and grounded in a shared world.

## Final remarks

The potential for ecologies of knowledges emerging through the encounters and dialogues of biomedical knowledge and MTCI/PICS enables dimensions such as emotion, intuition and sensitivity to play a role as important as the intellect in addressing suffering and the search for well-being. The failure to incorporate these other dimensions into health care stands in the way of engaging with life as a whole and to the multiple intersecting dynamics which constitute the process of health-disease-care. And, therefore, it tails as well in recognizing experiences, knowledges and practices which are not captured by biomedical knowledge and practice.

Integrating different therapeutic resources in a complementary, conscious and responsible manner expands the possibilities of coping with health problems. Ecologies of knowledges may emerge from the encounters and articulations of the diverse therapeutic and healing knowledges and practices and biomedical knowledge, paving the way for decolonization in health. The health field has a central role to play in this process, but it has to expand its conception of health, incorporating its diversity and plurality of social knowledge and practices, to enable an expanded, intercultural conception of care.

Insufficient funding, training and research in PICS, as well as little or no legitimation and institutional recognition of a number of integrative practices contribute to the persistence of colonial traces in the public health system, calling out for reflection and action aimed at an intercultural agenda for health.

Despite all the potential for decolonizing practices associated with MTCI/PICS, their inclusion and development within SUS still face the crucial challenge of the recognition of other knowledges and practices, namely those born out of the struggles of indigenous peoples, black communities and traditional populations. Taking up this challenge calls for the expansion of collaborative, non-extractivist forms of research and intervention in health based on the mutual recognition of the diversity of knowledges and practices addressing suffering and promoting care as a pathway to the construction of ecologies of knowledges and practices in health.

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## Authors' contribution

Guimarães conceived and wrote the study. Nunes supervised it. Nunes, Velloso, Bezerra and Sousa discussed the ideas and contributed to the writing of the text. All authors reviewed and approved the final version.

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