Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.8
DOI: 10.1590/1413-81232024298.05132024EN

THEMATIC ARTICLE

The Invisibility of Integrative and Complementary Practices in Primary Healthcare

Pedro Henrique Brito da Silva (https://orcid.org/0000-0003-3552-0439) [1]
Leylaine Christina Nunes de Barros (https://orcid.org/0000-0003-1599-7571) [2]
Janaína da Câmara Zambelli (https://orcid.org/0000-0001-6269-7382) [3]
Nelson Filice de Barros (https://orcid.org/0000-0002-2389-0056) [4]
Ellen Synthia Fernandes de Oliveira (https://orcid.org/0000-0002-0683-2620) [5]

Abstract *Invisibility is an issue that requires more attention among healthcare professionals, as some activities in Primary Care go unnoticed. One example is the offer of complementary therapies, whose implementation has been frail and, consequently, can be overlooked in the Unified Health System. This study aims to understand the factors contributing to the public invisibility of Integrative and Complementary Practices in Primary Care. It is a descriptive, exploratory, and qualitative research involving semi-structured interviews with 20 professionals in the Metropolitan Region of Goiânia. Thematic content analysis was applied to the interviews, revealing elements indicating the public invisibility of these practices, such as insufficient discussion in team meetings, inconsistency in the recording in user files, and low prioritization in implementation. In the interviews, social humiliation, a product of public invisibility, can also be perceived due to overload, embarrassments, and lack of physical space for the provision of practices to the users. It is concluded that Integrative and Complementary Practices are often overlooked in Primary Care.*
Key words *Complementary Therapies, Primary Health Care, Health Personnel*

[1] Secretaria de Saúde do Município de Senador Canedo. Go 403 Km 9 - Morada do Morro. 75250-000 Senador Canedo GO Brasil. pedrobryto@gmail.com
[2] Secretaria de Saúde do Distrito Federal. Brasília DF Brasil.
[3] Programa de Pós-Graduação em Odontologia, Universidade Estadual de Campinas (Unicamp). Campinas SP Brasil.
[4] Faculdade de Ciências Médicas, Unicamp. Campinas SP Brasil.
[5] Programa de Pós-Graduação em Saúde Coletiva, Universidade Federal de Goiás. Goiânia GO Brasil.

Introduction

The institutionalization of Integrative and Complementary Practices in Health (PICS, *Práticas Integrativas e Complementares em Saúde*), in 2006, through the approval of the National Policy on Integrative and Complementary Practices (PNPIC, *Política Nacional das Práticas Integrativas e Complementares*), was a major milestone for public health in Brazil[1]. This document included five medical specialties to the list of services offered by the Brazilian Unified Health System (SUS): Homeopathy, Traditional Chinese Medicine; Phytotherapy; Anthroposophical Medicine and Thermalism/Crenotherapy. In 2017[2] and 2018[3], other PICS were added to the PNPIC, totaling 29 therapeutic practices included and offered, preferably, in Primary Health Care (PHC).

In fact, there is an interface between PHC and PICS[4] and health information systems confirm this statement. In 2018, according to the Health Information System for Primary Care (SISAB, *Sistema de Informação de Saúde para a Atenção Básica*), they were present in 4,159 Brazilian municipalities, 90% of which were implemented in PHC[5]. According to the National Registry of Health Establishments (CNES, *Cadastro Nacional de Estabelecimentos de Saúde*), in 2020, 78% of the offer was found in PHC[6]. This affinity can be explained by the plurality of guiding principles and care tools shared by PHC and PICS, such as comprehensive care, person-centered embracement, encouragement to the individual's autonomy in self-care, strengthening the bond, the welcoming listening, the horizontality of communication, the recovery of touch and affection and the appreciation of community orientation[7].

However, health professionals offering PICS often face political problems in Basic Health Units (BHUs) when offering care that is "different" from conventional care in their workplace[8-10]. The management of the service offering has been led by professionals; however, it faces challenges due to the lack of support from BHU managers and the need for their own funding sources to acquire essential materials for implementing the service. Nevertheless, those who are dedicated to providing more welcoming and humanized care, as opposed to the cold technical procedures of contemporary Western medicine, do not see the precariousness of work as a significant obstacle. These professionals' primary objective is to offer comprehensive care, aimed at meeting the needs and mitigating the suffering of those who seek the health services they offer. In this context, facing the challenges associated with the precariousness of work is seen as an inherent part of these professionals' commitment to promoting patient well-being and quality of life.

That said, based on the study carried out with street cleaners at the University of São Paulo, the concept of public invisibility[11] was developed, which is defined as a psychosocial blindness, in which people have devalued jobs and, consequently, are spurned[12,13]. A product of invisibility, social humiliation, is developed with the devaluation and decrease in the importance of the produced actions. They are expressed words and subliminal messages that may not even be consciously perceived but are felt. With it, opportunities for growth, development, knowledge production and citizenship are taken away, as well as the elimination of the feeling of having rights[11-14].

Public invisibility and social humiliation occur in minority groups and those with fewer social rights[15,16]. Therefore, such phenomena occur with sweeping workers[17], cleaning workers[18], homemakers[19], collectors of recyclable materials[20] and endemic disease control agents[21]. Moreover, Oliveira[22] identified the occurrence of these social phenomena endured by community health agents performing Lian Gong, a body gymnastics originating from Traditional Chinese Medicine, in the Metropolitan region of Campinas.

In this context, it seems quite bold to provide "other" care in health institutions in the face of this scenario that is not conducive to the "different". At the same time, this commendable boldness in offering PICS to users can reveal oddities, tensions, conflicts, separations and constraints to the health professionals who offer them in the services. Thus, the PICS take on a "precarious integration", as they can highlight a separation between "inside" professionals, linked to biomedicine, and those "outside", who develop non-protocol practices.

Additionally, the precariousness of working with PICS in PHC is evidenced by the conflict between carrying out these practices and other activities considered priorities in health services. The accumulation of functions by professionals who offer these practices, combined with the high number of users treated in groups by a single professional, represents a significant challenge, potentially compromising the quality of the provided care. The overload of responsibilities and the shortage of human resources can have adverse impacts on the effectiveness of PICS in PHC. The need to balance different demands and the high demand from users can result in

Ciência & Saúde Coletiva, 29(8):1-11, 2024

a less efficient and individualized service provision, negatively affecting the patient experience and the effectiveness of the adopted practices[22,23].

Thus, these findings can further corroborate our assumption that invisibility may also be happening to professionals offering PICS, as their implementation in PHC can signal the growth of the counter-hegemonic order of health care and the experience of constraint practiced by other workers who constitute the multidisciplinary team[24,25]. It is in this sense that this study presents itself, culminating in the following question: what factors produce social humiliation and public invisibility of PICS in PHC? In view of this, the aim of the article is to understand the existence of factors that indicate the production of public invisibility of Integrative and Complementary Practices in Primary Health Care in the metropolitan region of Goiânia (MRG), state of Goiás, Brazil.

Methods

This is a descriptive, exploratory analysis with a qualitative approach, developed with the results of a Master's Degree dissertation entitled Integrative and Complementary Practices in Primary Health Care: Perceptions of professionals on the provision of services in the Metropolitan Region of Goiânia, arising from the Program of Postgraduate Studies in Public Health at Universidade Federal de Goiás on the meanings that health professionals attribute to the provision of PICS in PHC. The research is also part of the macroproject whose title is Integrative and Complementary Practices in Primary Health Care services – Metropolitan Region of Goiânia. This study also represents the extended version of the text published in the Minutes of the Ibero-American Congress of Qualitative Research (CIAIQ 2022)[26].

Three municipalities were excluded from this project: two municipal health secretariats did not authorize the study to be carried out and one did not respond whether they consented to the development of the research or not. According to CNES[27], there are 234 PHC services in the 17 municipalities participating in the research. Of these, 54 did not participate in the study, as they were not in operation (building renovation and/or were not contacted via telephone). A census was carried out with the managers of 180 services in MRG municipalities to identify which professionals implemented PICS in PHC. In the second half of 2017, there were 23 services, in which 29 professionals offered some type of PICS, in five municipalities of the MRG.

Of the 29 identified professionals, 22 met our inclusion criteria: health professionals who offered some type of PICS in PHC in the MRG. Seven professionals did not participate in the study: one refused to participate; three were not contacted and three had discontinued the availability of PICS at their respective BHU. Our exclusion criteria included those health professionals who, due to absence from work, vacation or leave of absence of any nature, were not in the PHC services in the MRG during the data collection period, which comprised the months of January to August 2018. Therefore, two professionals were excluded, as both were on paid leave. Finally, the present study involved the participation of 20 professionals from 14 PHC services, in three municipalities in the MRG.

We decided to collect data from all professionals who qualified and agreed to participate in the study, as we considered that we could not ignore unique information, which would stand out and unique experiences, of which explanatory potential could be important for discovering the logics internal to this group. We also considered favoring PHC health workers in the MRG who had the attributes, characteristics, experiences and expressions capable of satisfying our research question[28].

Data collection was carried out through semi-structured interviews, that is, guided by a previously prepared script addressing basic questions relevant to the investigation. We chose this methodological strategy because it is the most commonly used in research involving the meanings and perceptions of PHC professionals about PICS[29,30]. Moreover, the interview allows acquiring deeper knowledge about the researched object, as it provides continuous adjustment of the process based on questions and answers, dialogues and reflections, which emerge from the interaction[31]. The instrument used for data collection consisted of four modules, namely: sociodemographic profile; training process; work with PICS; and valorization of PICS at the BHUs.

The interviews were conducted by a single male researcher, student of a Master's Degree program in collective health and physical therapist at a family health center belonging to a municipality that is part of the MRG. However, this municipality did not offer PICS in its BHUs. As a result, the researcher did not know or have previous contact with those being researched. It

is worth noting that the interviewer had previous experience with conducting structured interviews in other research projects. Therefore, we decided there was no need for preparation or training for the researcher, as he is familiarized with this type of data collection from participants in other studies.

The individuals were invited to participate in the study by the researcher via telephone contact. At this point, the researcher's credentials as a Master's Degree student and member of the macro research project team were presented. During this first contact, the interviewee was also informed that it was a study to complete the researcher's Master's Degree, as well as the purpose, risks and benefits of the research. Upon acceptance, days and times were scheduled for the interviews, at the professionals' workplaces.

Subsequently, we carried out the visit reinforcing the objectives of the study, guaranteeing the anonymity and confidentiality of the information. Upon agreement, the Free and Informed Consent Form (TCLE) was presented to be read and signed. The participants' rights were protected by providing information on all relevant aspects of the research, including its risks and benefits. As provided for by Resolutions No. 466/2012 and No. 510/2016 of the National Health Council and Ministry of Health, the project was approved by the Research Ethics Committee of Universidade Federal de Goiás, under Opinion No. 2,057,783. During the interview, carried out in the BHU medical offices, there was no one else present besides the researcher and the participant. The interviews lasted, on average, 45 minutes, were audio recorded and transcribed in full.

We also used the first two interviews with the aim of checking possible inconsistencies, question complexities, ambiguities or inaccessible language, existence of questions that caused some constraint to the interviewee, inconsistency in the order of the questions, whether the questions were too numerous and to observe whether the expected interview duration would be adequate or not. There was no need to adapt the instrument, as we observed that the interviews had a satisfactory duration and were capable of capturing the information necessary to answer the research questions.

The obtained data were analyzed using Thematic Content Analysis[32]. We used a program to support the qualitative analysis, the software NVivo© Plus, version 12, which helped organize the data, allowing a more standardized analysis and permitting the analysis by more than one researcher. We assigned each interview transcript the letter "P", plus the number assigned to each research participant corresponding to the order in which the invitation was made.

We started with the pre-analysis to organize the material to be assessed, providing the first contact and the moment in which we started to learn about the contents of the documents transcribed from data collection, through skimming reading. Subsequently, we examined the material, in which, at this stage, one must resort to the interpretative process to create the categories. At this stage, codes with similarities in terms of semantic criteria were identified and text fragments that, in fact, represented the most significant arguments were selected. Subsequently, we carried out the coding using the deductive method, that is, beforehand, in which the categorization was carried out in advance. Figure 1 illustrates the thematic categories resulting from the codes. The last stage of data analysis consisted of processing the obtained results and interpreting them according to the proposed objectives in light of the concepts of social humiliation and public invisibility based on studies by Costa[11] and Gonçalves Filho[12,13].

Results and discussion

Twenty health professionals were interviewed. The sociodemographic characteristics of the study participants are shown in Table 1.

The social humiliation of professionals offering Integrative and Complementary Practices in Primary Health Care

Social humiliation is a constitutive phenomenon of public invisibility, in which individuals are affected by anguish, as they are affected by the actions of others in relation to their work. People feel belittled by those who make them feel inferior[13,16]. In our analysis, these words mean that there is a relationship of imbalance and inequality, of the supposed superior being – the biomedicine professionals – compared to the "inferior" being – the PICS operators.

This becomes very evident when professionals have the right to perform PICS on the day established for this purpose; however, this is not always respected, as they cannot be absent from services due to tasks considered as priority by BHU management and Municipal Health Secretariat managers. Therefore, there is a hierarchical and controversial subordination in the work pro-

Ciência & Saúde Coletiva, 29(8):1-11, 2024

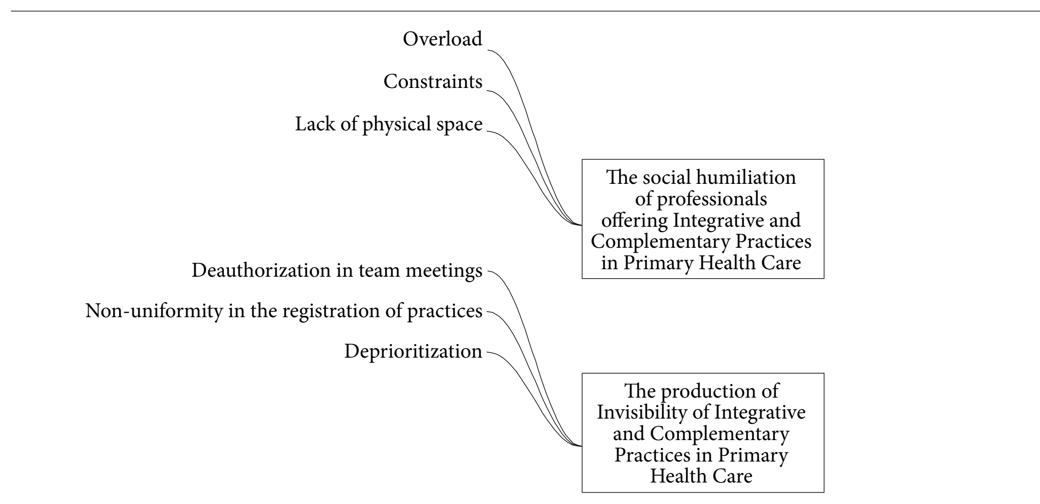

Figure 1. Synthesis of codes and thematic categories based on the content of interviews with Primary Health Care professionals in the Metropolitan Region of Goiânia offering Integrative and Complementary Practices between the months of January and August 2018.

Source: Authors.

cesses of these professionals. They have a certain autonomy to offer the services; however, they do not have the independence to choose which activities they should prioritize at the BHU.

Likewise, nurses performing Auriculotherapy at the BHU feel overwhelmed, as they cannot abandon their other activities, considered to be basic in the work process at PHC. One of them stated that:

It was getting a little difficult, because even the manager came to tell me: "look, there are other groups". Then, as they wanted me to increase the number of points [at auriculotherapy], I said: "no, it's not possible" (P14).

These professionals experience a process of overload that adds to the different formats of devaluation of their work. Although they realize the consequences of task accumulation and social demotion, they do not emphasize their right to "complain", to demand better working conditions, possibly due to the unconscious submission and the feeling of not having (or having fewer) rights[15,33]. The reports of a psychologist who offers Community Therapy add more details about the obstacles experienced in developing PICS in PHC. The narratives show that the difficulty in obtaining permission to deal with PICS is also related to a disbelief about the practice. As she stated,

I don't feel an appreciation for the work. When I told them [team] that I wanted to train and sensitize people to occupy this leadership position that I occupy today [in Community Therapy] [...] I was "attacked" until I said enough was enough. When I went to talk about this possibility, the two colleagues who have training, postgraduate degrees in Community Therapy, [said:] "no, you're throwing my diploma in the trash". So, if I want to do Community Therapy, it's because I want to. Because my work had to be done here within four walls (P5).

Of course, this "barrier", over time, takes on the dimension of a subtle blow, a message that undermines your strength, your wishes, your will. A feeling of anguish, of devaluation, of disinvestment, of loneliness. In their words:

I'm not a specialist in Community Therapy, but I do it with great care, with great pleasure and I like what I do and I see that it has a result, no one wants to touch it, no one wants to change it. Are you enjoying doing it? So, keep doing it (P5).

One can observe in their reports a mix of satisfaction and recognition of their importance at work, but also a feeling of anguish due to the disrespect and disregard when offering these practices to users. Furthermore, the lack of knowledge and lack of support when working with PICS leads to the professional's humiliation, as their work is considered a pastime: "*It gives the impression that it's just a waste of time, it doesn't work. The professionals have difficulty seeing us leaving, not treating patients here and treating them outside*" (P5).

Table 1. Profile of professionals offering Integrative and Complementary Practices in Primary Health Care in the Metropolitan Region of Goiânia between the months of January and August 2018.

Characteristics	Frequency (Percentage)
Sex	
Female	18 (90)
Male	02 (10)
Age range	
21 to 30 years	02 (10)
31 to 40 years	08 (40)
41 to 50 years	03 (15)
51 to 60 years	07 (35)
Ethnicity/Skin color	
Yellow	01 (05)
White	09 (45)
Brown	08 (40)
Black	02 (10)
Religion	
Catholic	08 (40)
Spiritist	05 (25)
Protestant	04 (20)
Not declared	03 (15)
Level of schooling	
Higher Education	18 (90)
High School	02 (10)
Integrative Practice offered	
Acupuncture	02 (4.65)
Art therapy	02 (4.65)
Auriculotherapy	09 (20.9)
Reiki	03 (6.97)
Shantala	01 (2.32)
Community Therapy	03 (6.97)
Profession	
Health agent	01 (05)
Social worker	02 (10)
Dental surgeon	01 (05)
Nurse	06 (30)
Pharmacist	02 (10)
Physical therapist	02 (10)
Nutritionist	02 (10)
Psychologist	02 (10)
Nursing technician	01 (05)
Occupational Therapist	01 (05)
Total	20 (100)

Source: Authors.

There is a "misunderstanding", with contradictory and inconsistent messages transmitted by the team and service coordination. On the one hand, they are considered important and even fundamental, but, on the other, they are not part of the priority framework. Gonçalves Filho[12,13] helps us understand the issue by stating that social humiliation is a historical, political, external phenomenon, socially constructed over time and also internal to the individual and psychological aspect. In other words, it refers to an effect of political inequality, removing an entire class of subjects from the intersubjective context of initiative and speech.

Many interviewees reported a feeling of being separated, unable to express themselves, of showing the value and effectiveness of the practice. Through all these perceptions, they identify a non-validation of PICS as part of the PHC therapeutic arsenals and their undervaluation as providers of these practices. Such facts are evident in the excerpts that follow, in which the interviewees state that: "*One thing that is quite alienating is thinking that what happens in the service has nothing to do with [community] therapy. It's as if it doesn't belong in the service*" (P5).

This impossibility of enjoying the offer of PICS with their peers culminates in a feeling of sadness and social humiliation, as some feelings mark those who are humiliated[16]. This feeling of non-belonging and the creation of an environment of inequality between biomedical professionals and hybrid ones – offering biomedical and complementary care – reverberates the situation in which interviewees are ignored and disappear in the eyes of others. The humiliated person, in turn, has the feeling of not being like all people who have rights and are always on alert, that is, ready to receive a reprimand. The treatment given to these people denies their social participation through words and images associated with disbelief[12,13].

The interviewed professionals declare difficulties in the technical and political space, but the physical space itself is a concrete problem. There are no appropriate spaces within the units to carry out the PICS. It is often held in squares, church halls, auditoriums, BHU reception, neighborhood associations, meeting rooms, service rooms, benches in external areas, the entrance to the unit or at the back of it. The narrative below exposes this lack when the interviewee states that: "*We have a place here that belongs to the Catholic church and they lend the community hall for us to work, for us to meet*" (P6).

The lack of adequate space to carry out a non-biomedical practice within the health service, as reported by several professionals, is a phenomenon also observed in Israel and called

Ciência & Saúde Coletiva, 29(8):1-11, 2024

"spatial marginalization"[34]. It was observed in that country that PICS are developed in environments located far from health services or even outside their coverage territory. Thus, the professionals are admitted to the services, but on the periphery of their social and geographic space, taking on the imaginary role of a being from another world.

This tension, sharing the same work environment, can be explained by the concept of boundary at work. In it, the exclusion and marginalization of some professionals occur, with them being identified as outsiders, through the multidimensional processes of defining the symbolic borders in the field[35].

There are many consequences of continued social humiliation and, from a collective point of view, it can lead to the loss of the will to create and carry out humanized forms of care. The individual and collective losses that are being produced by teams of professionals and health service managers who do not support the professionals who offer PICS are significant. The undervalued work with undervalued care practices reduces the will of many health professionals to be "actors" and agents of change. As a result, they care less about the community's quality of life and replace the life-producing practices of their care by sterile practices.

The production of public invisibility of Integrative and Complementary Practices in Primary Health Care

Although the professionals work with biomedicine, the dominant rationality, when they are exercising their role with complementary and alternative rationalities and practices, they are made unfeasible. This situation is similar to that of Costa[11], since in his experience working as a street sweeper at Universidade de São Paulo, even though he was a student at the university itself, having a certain social "status", he was not seen. His uniform made him invisible to others. Similarly, when the interviewed professionals position themselves as performing care that is "dissimilar" to conventional and hegemonic care, they are not noticed even if they have a higher education degree.

This finding contrasts with the results of other studies, in which invisibility is predominantly observed among workers with a lower level of schooling[17-20]. In Primary Health Care (PHC), the situation presents itself differently, affecting workers with a higher level of schooling. According to Costa, the invisibility permeates various social groups in a subtle way, by exposing themselves to subjugation by those considered "superior". In the context of the interviewees, it becomes clear that having a university degree is not enough for them to automatically submit to the prevailing logic.

The professionals are also included in this process of exclusion of their rights, as, during the provision of PICS, they are not recognized as biomedical professionals. They are submitted to subjugation, as they are involved in providing care that, mistakenly, is considered ineffective by some professional categories. The effectiveness of Yoga in treating low back pain, for instance, is clearly evident[36]. However, we find professionals who are vehemently against the inclusion of PICS in the Brazilian Public Health System (SUS, *Sistema Único de Saúde*).

Consequently, it was expected that professionals who have the knowledge and incorporate these complementary therapies into their work environments would face the phenomenon of social humiliation. Those who consider themselves "superior" for adhering exclusively to biomedicine as the only holder of true scientific knowledge use invisibility as a strategy to undermine actions related to PICS. From the point of view of those who dominate this situation involving PICS, the idea of being trained in contemporary Western rationality and also recognize rationalities considered "non-scientific" is seen as unacceptable. Thus, public invisibility, through its subtle actions, aims to suppress care that diverges from the biomedical approach.

Hence, a means of canceling PICS is evidenced by the non-uniformity of records in the users' medical files and deauthorization during team meetings. According to Costa[11], public invisibility produces the intersubjective disappearance of a man among other men. Subordination as a means of oppression is evident in the reports of professionals who are not authorized to talk about their work during team meetings:

It's very difficult to bring up the subject, because people don't believe in it. There is no interest on the part of the team... Maybe I don't know how to adequately inform the characteristics of the work, what is to be done, what can be done and what the advantages of this work are (P16).

These workers emphasize the feeling of not being allowed to report their work with PICS and even question themselves whether they are wrong for not discussing the subject. Thus, a vicious circle ensues: professionals do not feel safe

to share their experience with the team, the team, in turn, ends up not being interested in the practice, not encouraging its explanation, and, as a result, the cases are not discussed. and the patients are not monitored.

The team meeting is an opportunity for people to show themselves, in which their personalities and individualities emerge more clearly and are important for the organization and structuring of work, for the establishment of guidelines, being a crucial moment for decision-making. During meetings, patient cases can be discussed from an interdisciplinary perspective, with the construction of collective projects and care plans[37].

However, the participants describe the feeling of not being on "equal footing" with biomedical professionals, therefore occupying a place of inferiority. The occupation of this subordinate position demonstrates the existence of a game of power and domination between the different "included" health professionals, restricted to allopathic practices, and the "excluded" ones, who provide other care practices in PHC[23].

This result is in line with the study by Oliveira[22] and the presence of PICS creates tension with the dominant paradigm, with the viewpoint centered on the disease, on the hospital, on biomedicine. This entire context generates conflicts, power struggles, not only for those who are "in charge", for those who have the knowledge, but also for those who are authorized to "care", to "be recognized" as a health professional[10].

The lack of discussion on PICS in team meetings extends to the lack of information in the practitioners' records, which is an important means of communication between professionals, working as an instrument of integration of the health team to develop PHC care coordination. The medical record is essential for the longitudinal monitoring of patients and for information to be transferred to different specialists, thus ensuring the continuity of care[38].

The information about PICS practitioners is recorded in different ways: sometimes in physical or electronic records, sometimes in notebooks and minute books. However, some interviewees reported that they do not record PICS use in the participants' medical records. Therefore, professionals do not take ownership of what they do, they are unable to evaluate their patients' progress in the presence of the team, perhaps losing the identity of true caregivers.

Furthermore, reification is evidenced in the content of the interviews as another factor to reinforce the occurrence of the invisibility of PICS[12,13]. Reification is characterized as a process by which the value (of people, objects, institutions, relationships) is presented to human consciousness as a value, above all, economic, as an exchange value, a commodity. Therefore, reified work does not appear for its qualities, as a concrete work, but as an abstract work, to be sold. Relationships are thus created between things. With this, man disappears, and remains in the shadow. Everything starts to count, primarily, as a commodity, that is, man is transformed into a thing[12,13]. The reification is evident in the following reports: "*We take records in this notebook. Because productivity is required, to launch on the computer*" (P7); "*We need to launch these users in the city hall system*" (P9).

In short, social humiliation and public invisibility are broader issues than it seems. It is not just a simple lack of space in the agenda of team meetings for discussions, or a lack of request from the coordination for professionals to keep the medical records updated regarding the patient's life. Therefore, it is a regular fact, as observed in the professionals' narratives, and, without a doubt, this raises the suggestion for new research based on the question: what losses and impacts, not only to the PICS, but also to the entire team, to the health system and, mainly, to users, are caused by public invisibility and social humiliation?

The PNPIC underwent two updates in the last four years and the scope of PICS offered by the SUS was expanded to 29 different practices[2,3]. Therefore, the scope of PICS offered by the SUS was expanded during the research period, considered a temporal limitation of the study. The spatial scope can also be considered a methodological limitation, and it is important to carry out more studies to reinforce the presence of these phenomena among professionals offering PICS for the external validation of the findings evidenced herein.

Immersed in this "precarious integration"[8], of reproduction of knowledge and constraints by pre-existing hierarchical relationships, professionals seem to be unable to establish a legitimate communication of the place that belongs to them among PICS care practices in PHC. They are authorized to exercise their knowledge, by right gained through the PNPIC; however, their ability to speak and act in an authorized manner and with authority does not seem to occur in the health services[15].

Ciência & Saúde Coletiva, 29(8):1-11, 2024

Final considerations

Our study analyzed PICS in PHC services of the MRG from the perspective of health professionals and led us to conclude that their work faces symbolic difficulties that circumscribe multiple modes of public invisibility and social humiliation. The evidence from this study suggests that alternative professionals suffer from epistemological apartheid, as PICS also do not exist in discussions between PHC service teams. They face cultural erasure, that is, the biomedical power unconsciously defines them as inferior. The establishment, that is, the norms and control of the ruling class (biomedicine), expels the performance of PICS from within health services, placing them in improvised, inadequate spaces and/or in the "back or outside" of the units. Moreover, they suffer from the omission of management and other professionals who constitute the health teams to support their implementation.

Another important piece of information found that reinforces the presence of invisibility was the lack of records of PICS in the users' medical files. The PNPIC could represent a social and historical achievement. Taken together, the results of this study indicate that PICS are included but are still left "outside" the Health System. Even though they are part of the service, they are seen as something extra, an additional thing, which are not linked to the other activities, care and care practices.

This study has gone forward towards expanding the understanding of public invisibility among health workers. Therefore, the offer of PICS can be considered as yet another invisible job in society. These conclusions can guide how PICS can be implemented, considering how this process should be carried out, and the problems faced and highlighted by professionals in our study. This would be extremely important so that the offer can be expanded and its potential benefits can reach a significant number of SUS users.

Collaborations

PHB Silva, LCN Barros, JC Zambelli, NF Barros and ESF Oliveira contributed substantially to the concept and planning of the study; to the collection, analysis and interpretation of data, writing of the manuscript and its critical review and approved the final version to be published.

References

1. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Práticas Integrativas e Complementares no SUS. *Diário Oficial da União* 2006; 3 maio.
2. Brasil. Portaria nº 849, de 27 de março de 2017. Inclui a Arteterapia, Ayurveda, Biodança, Dança Circular, Meditação, Musicoterapia, Naturopatia, Osteopatia, Quiropraxia, Reflexoterapia, Reiki, Shantala, Terapia Comunitária Integrativa e Yoga à Política Nacional de Práticas Integrativas e Complementares. *Diário Oficial da União* 2017*;* 27 mar.
3. Brasil. Ministério da Saúde (MS). Portaria nº 702, de 21 de março de 2018. Altera a Portaria de Consolidação nº 2/GM/MS, de 28 de setembro de 2017, para incluir novas práticas na Política Nacional. *Diário Oficial da União* 2018; 21 mar.
4. Tesser CD, Sousa IMC, Nascimento MC. Práticas Integrativas e Complementares na Atenção Primária à Saúde brasileira. *Saude Debate* 2018; 42(n. esp. 1):174-88.
5. Barbosa FES, Guimarães MBL, Santos CR, Bezerra AFB, Tesser CD, Sousa IMC. Oferta de Práticas Integrativas e Complementares em Saúde na Estratégia Saúde da Família no Brasil. *Cad Saude Publica* 2020; 36:e00208818.
6. Amado DM, Sena BFE, Santos LND, Araújo MLT, Sousa RPR, Dall Alba R. Práticas integrativas e complementares em saúde. *APS* 2020; 2(3):272-284.
7. Ribeiro LG, Marcondes D. A interface entre a atenção primária à saúde e práticas integrativas e complementares no sistema único de saúde: formas de promover as práticas na APS. *APS Rev* 2021; 3(2):102-109.
8. Barros LCN, Oliveira ESF, Hallais JAS, Teixeira RAG, Barros NF. Práticas Integrativas e Complementares na Atenção Primária à Saúde: Percepções dos Gestores dos Serviços. *Esc Anna Nery* 2020; 24(2):e20190081.
9. Habimorad PHL, Catarucci FM, Bruno VHT, Silva IB, Fernandes VC, Demarzo MMP, Spagnuolo RS, Patricio KP. Potencialidades e fragilidades de implantação da Política Nacional de Práticas Integrativas e Complementares. *Cien Saude Colet* 2020; 25(2):395-405.
10. Paradis E, Whitehead CR. Louder than words: power and conflict in interprofessional education articles 1954-2013. *Med Educ* 2017; 49:399-407.
11. Costa FB. *Homens invisíveis – relatos de uma humilhação social*. São Paulo: Globo; 2004.
12. Gonçalves Filho JM. A invisibilidade pública. In: Costa FB, organizador. *Homens invisíveis – relatos de uma humilhação social*. São Paulo: Globo; 2004.
13. Gonçalves Filho JM. Humilhação Social: humilhação política. In: Souza BP, organizador. *Orientação à queixa escolar*. São Paulo: Casa do Psicólogo; 2013.
14. Weil S. *A condição operária e outros escritos sobre a opressão*. Rio de Janeiro: Paz e Terra; 2008.
15. Jardim DF, López LC. *Políticas da Diversidade: (In) visibilidades, pluralidade e cidadania em uma perspectiva antropológica*. Porto Alegre: Editora da UFRGS; 2013.

16. Nascimento JCP. A invisibilidade pública e social dos trabalhadores: uma revisão da literatura sobre trabalhos invisíveis na sociedade. *REASE* 2022; 8(12):149-160.
17. Bobadilha BG. *Invisibilidade pública na atividade de varrição: Uma pesquisa-intervencionista para formação de agência transformativa no trabalho* [dissertação]. São Paulo: Faculdade de Saúde Pública; 2020.
18. Cardoso PS, Silva T, Zimath SC. Todo mundo olha, quase ninguém vê: a percepção de trabalhadores operacionais com relação à invisibilidade social de seus trabalhos. *Cad Bras Ter Ocup* 2017; 25(4):701-711.
19. Monteiro RP, Araújo JNG, Moreira MIC. Você, dona de casa: trabalho, saúde e subjetividade no espaço doméstico. *Pesqui Prat Psicossoc* 2018; 13(4):1-14.
20. Sousa RR, Pereira RD, Calbino D. Memórias do lixo: luta e resistência nas trajetórias de catadores de materiais recicláveis da Asmare. *REAd Rev Eletr Adm (Porto Alegre)* 2019; 25(3):223-246.
21. Matos GCR, Silva JM, Silveira AM. Trabalho e saúde: a perspectiva dos agentes de combate a endemias do município de Belo Horizonte, MG. *Rev Bras Saúde Ocup* 2020; 45:e15.
22. Oliveira MCS. *As (in)visibilidades do Lian Gong na Atenção Primária em Saúde* [dissertação]. Campinas: Universidade Estadual de Campinas; 2018.
23. Barros NF, Spadacio C, Costa MV. Trabalho interprofissional e as Práticas Integrativas e Complementares no contexto da Atenção Primária à Saúde: potenciais e desafios. *Saude Debate* 2018; 42(n. esp. 1):163-173.
24. Ruela LO, Moura CC, Gradim CVC, Stefanello J, Iunes DH, Prado RR. Implementação, acesso e uso das práticas integrativas e complementares no Sistema Único de Saúde: revisão da literatura. *Cien Saude Colet* 2019; 24(11):4239-4250.
25. Takeshita IM, Sousa LCS, Wingester ELC, Santos CA, Aroeira AS, Silveira CP. A implementação das práticas integrativas e complementares no SUS: revisão integrativa. *Braz J Hea Rev* 2021; 4(2):7848-7861.
26. Silva PHB, Oliveira ESF, Barros NF, Barros LCN, Zambelli JC. Invisibilidade pública das Práticas Integrativas e Complementares e humilhação social dos trabalhadores que as ofertam na Atenção Primária à Saúde. *NTQR* 2022; 13:e645.
27. Brasil. Ministério da Saúde. *SCNES – Sistema de Cadastro Nacional dos Estabelecimentos de Saúde* [Internet]. Avaiable from: http://cnes2.datasus.gov.br/Mod_Ind_Especialidades.asp?VEstado=52&VMun=.
28. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. *Rev Pesq Qual* 2017; 5(7):1-12.
29. Roberts K, Betts D, Dowell T, Nie JB. Why are we hiding? A qualitative exploration of New Zealand acupuncturists views on interprofessional care. *Complement Ther Med* 2020; 52:102419.
30. Silva PHB, Barros LCN, Barros NF, Teixeira RAG, Oliveira ESF. Formação profissional em Práticas Integrativas e Complementares: o sentido atribuído por trabalhadores da Atenção Primária à Saúde. *Cien Saude Colet* 2021; 26(2):399-408.
31. Aspers P, Corte U. What is Qualitative in Qualitative Research. *Qual Sociol* 2019; 42:139-160.
32. Bardin L. *Análise de Conteúdo*. Coimbra: Edições 70; 2016.
33. Bosi A. Fenomenologia do olhar. In: Aguiar F, organizador. *O Olhar*. São Paulo: Companhia das Letras; 1988.
34. Shuval JT, Gross R, Ashkenazi Y, Schachter L. Integrating CAM and biomedicine in primary care settings: physicians' perspectives on boundaries and boundary work. *Qual Health Res* 2012; 22(10):1317-1329.
35. Fox NJ. Boundary Objects, Social Meanings and the Success of New Technologies. *Sociology* 2011; 45(1):70-85.
36. Wieland LS, Skoetz N, Pilkington K, Harbin S, Vempati R, Berman BM. Yoga for chronic non-specific low back pain. *CDSR* 2022; 11(11):CD010671.
37. Grando MK, Dall'agnol CM. Desafios do processo grupal em reuniões de equipe da estratégia saúde da família. *Esc Anna Nery* 2010; 14(3):504-510.
38. Pinto EC, Gomes DS. Prontuário do paciente: informações para a gestão em saúde. In: Pereira IB, Dantas AV, organizadores. *Iniciação científica na educação profissional em saúde: articulando trabalho, ciência e cultura*. Rio de Janeiro: EPSJV; 2008. p. 53-87.

Article submitted 10/10/2023
Approved 26/03/2024
Final version submitted 28/03/2024

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva

This is an Open Access article distributed under the terms of the Creative Commons Attribution License