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Integrative and Complementary Practices in Primary Health Care: Perceptions of Service Managers

Práticas Integrativas e Complementares na Atenção Primária à Saúde: Percepções dos Gestores dos Serviços

Prácticas Integradoras y Complementarias en la Atención Primaria de Salud: Percepciones de los Gestores de Servicios

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Abstract

Objective: To understand the meanings attributed by the managers of the Services of the Metropolitan Region of Goiânia to the offer of Integrative and Complementary Practices (ICP) in Primary Health Care (PHC). **Method:** Descriptive and exploratory study, with a qualitative approach, conducted between August and December 2017, with 21 managers, using semi-structured interviews that were recorded, transcribed, and analyzed with the thematic content analysis technique. **Results:** The interviewees demonstrated an understanding of the context in which the ICP are placed, although they have presented difficulties and insecurity expressing their concepts. The results have elicited three categories, as follows: ICP for managers; positive and negative aspects of the provision of ICP for the health team; positive and negative aspects of the provision of ICP for service users. **Conclusion and implications for the practice:** It is possible to conclude that there is a strong influence of the biomedical model, instead of a more integrated approach in the organization of PHC services, which leads to a low and discontinuous offer of ICP in the Metropolitan Region of Goiânia. This conclusion invites us to expand the spaces for reflection on the plurality of rationales of care in the Unified Health System.

Keywords: Complementary Therapies; Unified Health System; Integrality in Health.

Resumo

Objetivo: Compreender os sentidos atribuídos pelos gestores dos Serviços da Região Metropolitana de Goiânia sobre a oferta de Práticas Integrativas e Complementares (PIC) na Atenção Primária à Saúde (APS). **Método:** Estudo descritivo e exploratório, de abordagem qualitativa, realizado entre agosto e dezembro de 2017, com 21 gestores, mediante utilização de entrevistas semiestruturadas que foram gravadas, transcritas e analisadas com a técnica de análise de conteúdo temática. **Resultados:** Os entrevistados demonstraram compreender o contexto em que as PIC estão inseridas, embora tenham apresentado dificuldades e insegurança na sua conceituação. Dos resultados emergiram três categorias, quais sejam: PIC para gestores; aspectos positivos e negativos da oferta das PIC para a equipe de saúde; aspectos positivos e negativos da disponibilização das PIC para os usuários dos serviços. **Conclusão e implicações para a prática:** Conclui-se que há forte influência do modelo biomédico em detrimento da integralidade na organização dos serviços de APS, o que implica com a baixa e descontínua oferta das PIC na RMG. Esta conclusão convida para a ampliação dos espaços de reflexão sobre a pluralidade de racionalidades de cuidado no Sistema Único de Saúde.

Palavras-chave: Terapias Complementares; Sistema Único de Saúde; Integralidade em Saúde.

Resumen

Objetivo: Entender los significados atribuidos por los gestores de los Servicios de la Región Metropolitana de Goiânia acerca del ofrecimiento de prácticas integradora y complementarias (PIC) en la Atención Primaria de Salud (APS). **Método:** Estudio descriptivo y exploratorio, enmarcado dentro del quehacer cualitativo, realizado entre agosto y diciembre de 2017 con 21 gestores, por medio de la grabación y transcripción de entrevistas semiestructuradas que se analizaron con el uso de la técnica del análisis de contenido temático. **Resultados:** Los entrevistados demostraron comprender el contexto en el que se inserta las PIC, aunque presentaron dificultades e inseguridad en su conceptualización. Emergieron tres categorías de los resultados, cuales son: PIC para los gestores; aspectos positivos y negativos del ofrecimiento de PIC para el equipo de salud; aspectos positivos y negativos de la disponibilidad de PIC a los usuarios de los servicios. **Conclusiones e implicaciones de la práctica:** Se concluye que hay fuerte influencia del modelo biomédico en detrimento de la integralidad en la organización de los servicios de APS, lo que conlleva a la bajo y discontinuo ofrecimiento de PIC en la RMG. Esta conclusión invita a la ampliación de los espacios de reflexión sobre la pluralidad de racionalizaciones de la atención en el Sistema Único de Salud.

Palabras clave: Terapias Complementarias; Sistema Único de Salud; Integralidad en Salud.

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INTRODUCTION

Historical records reveal that health care and attention are characterized by therapeutic pluralism, with different techniques according to cultural, social, political and economic context.[1,2] The hegemonic western model of health care is the biomedical which, although effective for countless situations, has difficulty in providing quality care that respects culture, beliefs, and considers the complexity of the multiple dimensions of health problems.[3]

Given the need to integrate contemporary western medicine with unconventional health practices, the Ministry of Health approved, in 2006, the National Policy of Integrative and Complementary Practices (NPICP), which promotes diversified therapeutic proposals in the Unified Health System (UHS). The different Integrative and Complementary Practices (ICP) introduced since 2006 sought to increase effectiveness, safety, welcoming listening, therapeutic bonding and the integration of human beings with the environment.[4,5]

The NPICP advocated the public offering of Chinese traditional medicine – acupuncture, homeopathy, medicinal plants and herbal medicine, social thermalis/crenotherapy and anthroposophic medicine[4]. More recently, by publication of Ordinances No. 145/2017, No. 849/2017 and No. 702/2018, were aggregated: self-massage, auriculotherapy, massage therapy, art therapy, ayurveda, circular dance/biodance, meditation, music therapy, naturopathic treatment, osteopathic treatment, chiropractic treatment, reflexotherapy, reiki, shantala, integrative community therapy, yoga, apitherapy, aromatherapy, bioenergetics, family constellation, chromotherapy, geotherapy, hypnotherapy, laying on of hands, ozone therapy and flower therapy.[6,7]

Although these practices are used by a remarkable number of people, the institutionalization in Primary Health Care (PHC) has grown in not a very significant way.[8] This can be explained by the privilege given to scientific evidence that can be objectified statistically or in the laboratory, to the detriment of clinical evidence not directly associated with statistical significance. In addition, the applicability of ICP is generally motivated by an interest in providing differentiated, less expensive care and more consistent with the context of wholeness.[9]

The challenges are clear and were portrayed in the management report of the period 2006-2010, from the National Coordination of NPICP, published in 2011. Among them, the following stand out: training and qualification of professionals; monitoring and evaluation of services; supply of inputs; structuring of services in the public network; development/adaptation of specific legislation; investment in research and development of processes and products.

The impact of ICP reaches the economic, technical, socio-political, educational and research fields.[10,11] Nevertheless, although some Brazilian municipalities are incorporating these types of care, such as Campinas (São Paulo), Florianópolis (Santa Catarina) and Recife (Pernambuco)[12], it is still necessary to disseminate the ICP in the UHS. Therefore, it is necessary to broaden the meanings of professional practice anchored in integrative principles and in a sociability oriented by holistic values.

In this sense, this study sought to understand the meanings attributed by managers of services of the Metropolitan Region of Goiânia (MRG) about the supply of ICP in Primary Health Care.

METHOD

This research is characterized as descriptive and exploratory, with a qualitative approach, using interviews with 21 managers/coordinators of the PHC services from MRG, from August to December 2017. It presents relationships with the research completed in the Metropolitan Region of Campinas, in partnership with the Laboratory of Alternative, Complementary and Integrative Health Practices, of the Universidade Estadual de Campinas, and is the extended version of the text published in the Minutes of the Ibero-American Congress of Qualitative Research, which took place in Fortaleza - Brazil, in 2018.

The choice of the qualitative approach[13] was based on the possibility of applying techniques and instrumental resources appropriate to the understanding of cultural values and social representations, allowing to know how the relationships between the actors involved and the offer of ICP in the MRG are triggered. This region, composed of 20 municipalities, is considered the most expressive in the state of Goiás, as it has been showing progressive growth, either from the analysis of population indicators or in terms of Gross Domestic Product.[14]

Initially, the MRG's PHC services were verified in the National Register of Health Facilities (NRHF) system. In this, it was possible to identify 274 services, of which 70 were registered with the offer of ICP. For this study, the consent letter was obtained from 17 municipalities out of 20, totaling 234 PHC services.

Telephone calls were made to check NRHF records, and 53 of the 234 services were excluded, considering the criteria: renovating of the establishment; refusal to participate in the interview; local manager's agenda; and telephony problems. Thus, according to the assumption of including only the services that offer the ICP, 21 managers participated in the study, being 11 from the Family Health Strategy (FHS), five from the Basic Health Unit (BHU), three from the Academy of Health and two from the Family Health Support Center (FHSC). All managers interviewed, however, are concentrated in five municipalities of the MRG. The five municipalities in which the research participants work have the following health services network: Municipality 1 (two BHU, two FHS and one Health Academy); Municipality 2 (37 BHU and two Health Academies); Municipality 3 (48 BHU, 30 FHS and one FHSC); Municipality 4 (seven BHU and one Health Academy); Municipality 5 (ten BHU and one FHSC).

Inclusion criteria to participate in the study were: being a manager of one of the PHC services that offered ICP and being in full exercise of their activities, regardless of time in management. The manager denomination was assigned to those who occupied the management position and/or those of the team who worked in the coordination at the time of the interview. Managers who

were not at the study site during the data collection period were excluded.

To characterize the participants' profile, a questionnaire was applied with information on: age, gender, ethnicity, marital status, education, contractual position, type and length of management practice. The interviews, previously scheduled and recorded in digital format, took place according to the availability of participants in a private environment and available at the service. They were guided by a script composed of the following guiding question: What does Integrative and Complementary Practices mean to you?

The process of thematic content analysis was guided by the trajectory proposed by Bardin[15], which consists of a set of techniques for analysis of the enunciations in order to obtain, by systematic and objective procedures, the inference about what was thematized in the messages. The data organization included the three steps: 1) pre-analysis; 2) exploration of the material; and 3) interpretation of the results. The pre-analysis consisted of superficial reading of the material to identify participants' perceptions of the availability of ICP; the exploration of the material, in detailed readings of the senses identified, aiming to group the convergent/divergent ideas that emerged with greater relevance.

The text was dismembered into thematic categories, understood as "meaningful expressions or words according to which the content of a speech will be organized."[15:317] The organization and systematization of data was facilitated with the support of NVivo 12 software, a research support program with non-numeric and unstructured data.[16]

Participants' rights were protected by informing all relevant aspects of the research, including their risks and benefits (described in the Informed Consent Form). To preserve anonymity, respondents were identified by the letter M (Managers), followed by a number (1 to 21) corresponding to the order of invitation. The study proposal was approved by the Research Ethics Committee of the Universidade Federal de Goiás and approved under Opinion No. 2.057.783, on May 11, 2017.

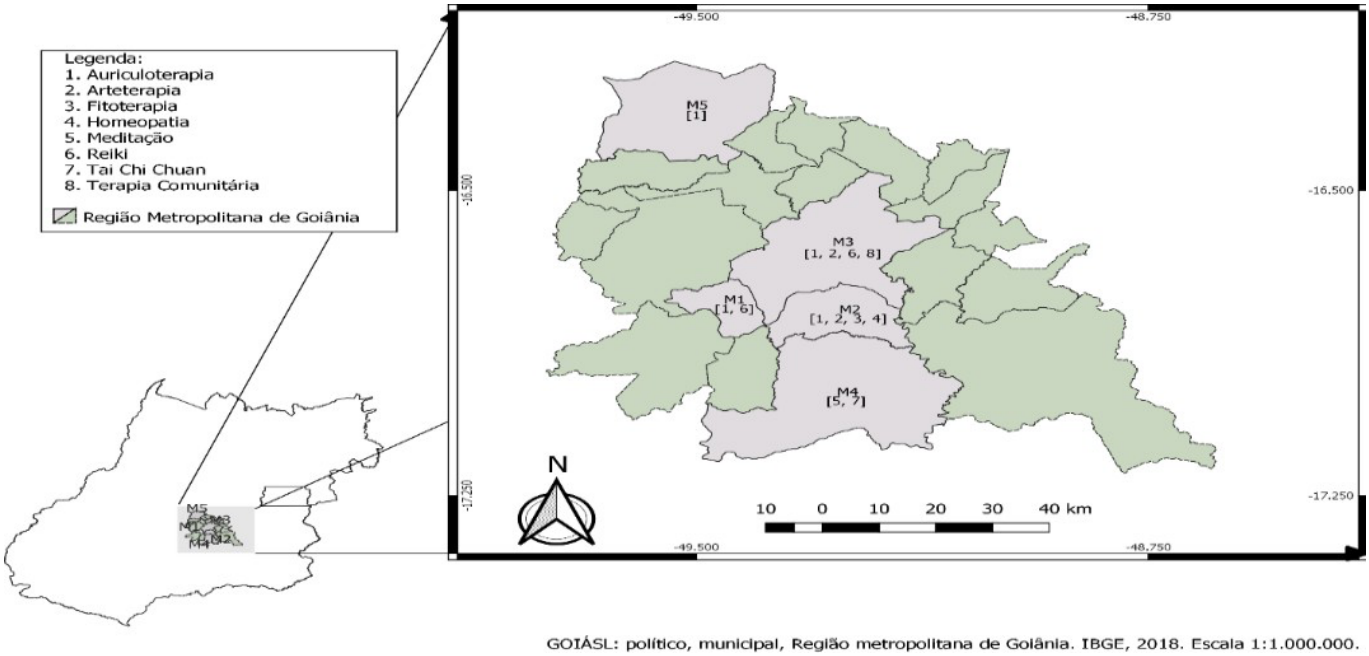
RESULTS

The number of units offering ICP (21) differs from the number registered in NRHF (70), in which there was a predominance of the availability of body practices / physical activity. From the total of 21 PHC managers/coordinators: seven (33.33%) were trained in Nursing, four (19.04%) in Physical Therapy, two (9.52%) in Human Resources Management, one (4 76%) in Public Health Management, one (4.76%) in Biomedicine and one (4.76%) in Nutrition; while five professionals (23.80%) had only high school.

As for age, the average age of 39 years prevailed. Most (N = 18 / 85.71%) were female, married (N = 16 / 76.19%) and self-reported as mixed race (N = 10 / 47.61%). The type of bond was statutory (N = 11 / 52.38%), commissioned (N = 7 / 33.33% /) and contracted (N = 3 / 14.28%), with management time between 5 and 48 months.

The managers referred to the offer of the following therapeutic modalities included in the NPICP: auriculotherapy, art therapy, herbal medicine, homeopathy, meditation, reiki, tai chi chuan and community therapy. The prevalent practice was auriculotherapy (present in four municipalities, named M in Figure 1), followed by art therapy. Such practices were identified in five MRG municipalities.

Figure 1: IPCs distribution by MRG municipalities in health services in 2017
Source: Brazilian Institute of Geography and Statistics – "IBGE" (2018).



Were identified in the participants' reports subthemes related to: difficulty in conceptualizing and exemplifying IPCs; health promotion and education strategy; user approach; comprehensive care; socialization; establishing and strengthening of bond; professional achievement; decrease in the expenses with medicines; job satisfaction; FHSC support; professional overload; lack of skilled human resources and basic inputs; precarious physical space; lack of recognition of managers; strengthening of self-esteem, socialization and satisfaction with the care received as a result of welcoming, integral and humanized care; little disclosure.

From these subthemes emerged the following three thematic categories: ICP for managers; positive and negative aspects of the provision of ICP to the health team; positive and negative aspects of making ICP available to service users.

I. ICP for managers

This category portrays the perceptions of PHC service managers regarding the use of ICP in health care, as well as the influence of this experience on professional practice. The name Integrative and Complementary Practices was reported with difficulty:

> *Wow! I can't answer what this cooperative practice would mean.* [...] *I already did physical therapy, right, for a year* [...] *brought a very big improvement because I felt a lot of back pain and after I did this physical therapy I no longer feel pain* (M1).
>
> *I think it is the treatment of natural products that people can find in the corner of the house* [...] *something like that* (M3).
>
> *It is walking group and stretching group* (M12).

Although the empirical data present limitations and precariousness in the conceptualization and exemplification of ICP, participants understand the context by referring to comprehensiveness, health promotion and education and the strategy of approaching the user to the unit. In the words of one of the interviewees:

> *I think these practices come to bring the user closer to the health unit, right ... we can maintain a bond with the user and, on the other hand, improve their quality of life too* (M4).

Other perceptions evoked were the ideas of establishing a bond with the user and socialization, as well as offering the practice as complementarity and reducing medicine expenses:

> [...] *we make a bond, right! So, for example, when they are doing the actions, we, as part of the unit, also participate with them* [...] (M4).
>
> *It is a complement, a second chance* [...] *it is not only the person coming here and just consulting* [...] *the unit goes beyond that* [...] (M8).
>
> [...]*We just learn from each other* [...] *especially those who have depression. You know those most anxious people, who can't sleep at night, take a lot of medicine* [...] *you can control this part without the medicine* (M10).

Such speeches incite important aspects to be considered, since, as one visualizes the benefits provided to users, the offer is valued, which also tends to cooperate for professional growth and achievement. Situations like these are present in the responses of ICP facilitating managers, when they claim that the practice:

> *Influences. Because you see the return of that, you see the person there getting better.* [...] *Reaching out to you and sometimes you even crying: "Wow, Doctor, you don't know what this has done in my life"* (M10).

It is also worth mentioning the portrait of indifference given to practices, revealing a relative distance. As one respondent stated:

> [...] *I see no difference* [...] *thinking about all the activities that are offered. And even due to the fact that the population sometimes does not even know these integrative practices* (M9).

II. Positive and negative aspects of the provision of ICP to the health team

In this category, the benefits and obstacles of ICP for the health team are highlighted, according to the managers' perception. Often, it is unanimous in recognizing the strengthening of bond with users, coupled with the satisfaction of professionals (stimulating the continuity of the offer of these practices), as can be seen in the following excerpts:

> *I think there is proximity, because these patients who participate in the practices they have a greater bond with the professionals* [...] *their bond is stronger than of that patient who only comes every three months for the follow up* (M4).
>
> *I see, mainly, the satisfaction of professionals in seeing how much their work is being important to other people* [...] (M9).

However, as valuable as previous reports are, in practice, practitioners implementing ICP are the same directly involved in the overall care of users, which is why managers emphasized the positivity of FHSC support from the perspective of avoiding Professional overload:

> *I think that when FHSC comes here to give us this support, it takes some of our burden, because we, as managers and nurses, have a lot of work inside the unit and then it helps us do our job. task* (M5).
>
> *Even those who do these practices are specifically the people of FHSC* [...]*so we have it here* (M8).

Regarding the negative aspects of making ICP available to the team, some managers stated that they did not identify them. However, the data reveal the consensus regarding some difficulties for the effective implementation of these practices, namely: lack of qualified human resources and basic inputs; physical structure not available or precarious; and lack of support from municipal management, leading to individual and sporadic initiatives.

> *I think our biggest problem today is the structural problem, because, many times, we can't offer quality because of lack of material* [...] *some come once and then they don't want to come anymore* [...] *then you have to bring it from home* (M4).
>
> *We need to train more people, because if we have more professionals we can offer to a larger population and publicize more* [...] (G13).
>
> *Sometimes we want to do something, but if we do not bear that, it does not happen* [...] *sometimes, what is missing is this: the incentive* (M14).

Also relevant is the role of professionals who develop voluntary work to make ICP available in PHC services. In the words of one of the managers interviewed:

> *The nurse makes the auricle and the dentist began to take the course. They felt the need to do something more for patients* (M6).

III. Positive and negative aspects of making ICP available to service users

The ability of ICP to produce meaning in users' lives was recurrent in the speeches. Participants emphasized the following benefits: strengthening self-esteem, socialization and satisfaction with the care received as a result of welcoming, integral and humanized care. Being all these benefits built or enhanced through the participating in the ICP:

> *I think that self-esteem* [...] *sometimes, the person needs, they are alone and then arrive at the unit and have such a therapy, sometimes they do not need medicine* [...]*their lives changes completely, their self-esteem goes up, they feel valued* [...] (M11).
>
> [...]*And with auriculotherapy, many patients praise our unit because of the way professionals are treating the population* [...] *the professional sees the patient as a whole, they see the patient in their whole* (M6).

Additionally, the impact on the reconstruction of interpersonal relationships, extended mainly to the family environment, must be considered:

> [...] *in the family is more willing. Many came and even told me:*
>
> *-Wow! I don't know what this is about auriculotherapy, but keep going, because there was a long time that you didn't even smile and you're smiling today* [...] *something that you haven't done for many years* (M10).

Negative topics were the cancellation of the offer of ICP when there was legal leave of the performer (vacation, sick leave) and insufficient disclosure of the practices in PHC services. According to respondents:

> *There is only one professional* [...] *and right now the professional has had surgery. So she is away, and the elderly are without anyone to do the practice. This is the downside. Now, if it were two people, it would be a little more positive* (M1).
>
> [...]*because sometimes you will talk to the person and she thinks it is a matter of religion and one thing has nothing to do with the other. So, more information for the public* (M10).

DISCUSSION

This was the first study on the provision of ICP in PHC health services at the MRG. In addition, the scientific production related to the theme in the region is insufficient, necessitating strengthening and expansion of the debates on the supply of ICP in the UHS.

It is important to highlight the numerical divergence between the services registered at NRHF and those that actually offer ICP in PHC at the MRG. Such occurrence may suggest outdated data, difficulties and/or limitations in data entry by the typist, possible errors in filling in the requested items in the register and underreporting.[17] Similar situation was portrayed in the investigation of the process of implantation of acupuncture in the public health services of 26 municipalities of the Regional Health Department XIII, of the State of São Paulo. In the research, it was identified the absence of records regarding acupuncture in 84.4% of Municipal Health Plans.[18]

There is a lack of knowledge and even insecurity of managers in the definition of ICP, as they mentioned biomedical practices. This aspect corroborates both the conceptual inaccuracy (confusing and masking reality), as well as the demonstration of fragility in the institutionalization, evaluation and monitoring of these practices.[17] Are these the reasons for the invisibility of ICP? Yes, it is possible, because the lack of knowledge, often arising from the lack of information in academic education, tends to contribute to the invisibility of ICP in the UHS.[19]

In six establishments, the availability of ICP was linked to eventual and/or emergency situations, considering the shortage of material and human resources. This fact allows us to glimpse that the ICP, even when inserted in the dynamics of PHC, are apart from other activities of the biomedical hegemonic pattern. In line with this finding, in a cross-sectional study on the knowledge of health managers in the municipalities of São Paulo about the Policy and the implementation of homeopathy in local health

services[20], it was evidenced that the lack of knowledge about homeopathic medical rationality and NPICP contributed to its non-implementation and deregulation in the municipalities. The little or no appreciation of ICP by managers and other team members is another element that contributes to the peripheralization of ICP in PHC in the UHS.[21]

It was noticeable in the reports of some interviewees a sense of indifference, such that the ICP are seconded in relation to their potential. Sometimes they are reduced to the narrow focus of illness, approaching the mechanistic conception or the prescriptive perspective, in which

> *there is a risk that such practices and medicines assume the same interventionist and curative format that has predominated in biologicist based medicine.*[22:365-366]

The potentials of ICP are, among others, structured in the positive conception of health as a way to overcome the fragmented look, thus filling gaps in the biomedical model. This is why the incorporation of these practices in PHC favors the complementarity of knowledge and contributes to a contextualized care to the real needs of individuals, making them protagonists in coping with the health-disease process[23]. The results thus allow to ratify the following statement: "The unprepared manager is today one of the critical nodes of the public service, because he provides discrepancies in the leadership needed to lead change processes and implement health policies [...]".[24:839]

In a study with health unit service coordinators on herbal medicine and other ICP, the importance of these agents in operating changes in production spaces was portrayed.[25] This implies the importance of teaching ICP in the training of health professionals, as the Learning from different rationalities (various therapeutic or health promotion practices, generally associated with each other), according to a technical and philosophical perspective, allows the expansion of possibilities in health care, considering the illness profile and the singularities of individuals[19,26]. Therefore, it is believed that an individual with knowledge can intervene directly in the therapeutic proposal, influencing himself and others. Therefore, investment in training and qualification to work with ICP in UHS should be a permanent action.[23,27]

In general, despite the interviewees showing difficulties to conceptualize the ICP, the benefits of offering these practices which they indicated interfaces with the concepts of comprehensive health care. They recognize that the incorporation of these practices is a dialogic action, in which symbolism and subjectivities become present, extending to the qualification in care delivery and, consequently, promoting the establishment of trust.

This result confirms the position of theorists on professional preparation combined with effective communication to promote respect for different conceptions related to health or care.[28,29] Respondents recognize the strengthening of the professional-user bond through attentive listening, permeated with empathy and affection, corroborating with other values associated with a higher quality of life, social integration, reduced use of medicines and stimulation of natural healing mechanisms.[30]

The FHSC team was cited as a supporter of PHC services. This team, in addition to being an integral part of PHC, is recognized as a partnership of FHS health professionals, either in the construction of flows or providing permanent education so that there is interaction of ICP with other offered practices.[31,32] In addition, it promotes greater dissemination of ICP in the health system, as it enables joint and interdisciplinary work, enabling the exchange of experiences and the construction of knowledge.[32] Nevertheless, the FHSC is not present in all municipalities surveyed.

On the other hand, the challenges related to the negative aspects presented in the narratives are clear, even converging with other studies. In the opinion of managers and health professionals regarding the implementation of ICP in the UHS, the main obstacles identified were the acquisition and supply of inputs, limiting the broadening of access to practices by users.[23] Such challenges have as potential obstacle the underfunding in the three spheres of management.[18,20] Another research on the experience of the Lian Gong's insertion in the Samambaia FHS (Federal District) showed that the lack of adequate places and the need to train a larger number of professionals is the biggest problem of the work with that ICP.[33]

In addition, insufficient systematized dissemination also makes it difficult to maintain ICP and, consequently, contributes to the non-acceptance of this holistic approach, which broadens the contextualization of regional specificities and relies on administrative, political and institutional planning for the construction of a prudent UHS.[28,34]

It is observed in the reports of managers who are also facilitators of ICP that personal experience with these practices triggers processes of resignification of health care. However, the search for ways based on the holistic view for the understanding of the health-disease-care process is not always appreciated by the interviewees, as they are often submitted to the norms defined by instances contrary to the establishing and implementation of ICP in the UHS.[35,36] In this regard, it is clear that socially legitimating ICP implies overcoming both the cyclicality of changes of rulers (suggesting the discontinuity of actions) and the unique truth of bioscience and specialized medicine in health care.[27,30]

It is also interesting to note a contradiction in the interviewees' speeches, because even with the positive aspects glimpsed, the managers showed the prioritization of other actions and the offer of ICP as an overload for the responsible worker. This result confirms the reflections presented in another study that discussed the potentials and challenges of interprofessional work with ICP in PHC.[37] This relationship reinforces an institutional culture rooted in the biomedical model, in which addressing the treatment and care of diseases limits other health promotion actions.[21]

It is considered urgent to blur this limited view, as a recent experiment to expand ICP to the FHS has shown itself promising in the sense of motivating hybrid practitioners (practitioners of biomedicine and ICP) to be instructors of other colleagues[34]. It is a possibility of expanding the clinic in order to choose the

most appropriate therapeutic resource, in view of interpretative enrichment and coexistence with therapeutic plurality.[26,28]

Thus, the need to give visibility and legitimacy to ICP is defended, as it is not a matter of including new professionals, nor of focusing on specialized attention, but of enhancing and making viable the practices already developed.[38] Therefore, the preparation of these agents will be essential to considerably influence the operationalization of the service in favor of other care models. Notoriously, the lack of knowledge and low dissemination of the offer of ICP allows the maintenance of health care directed to consultations and individual care, reinforcing the biologicist logic (centered on the medicalization of suffering) and blurring comprehensiveness.[21]

A single rationality is unable to answer all questions about illness. Therefore, in the association of diverse knowledge and practices, from an interdisciplinary perspective, one perceives a greater potential for technical and practical success. In light of this, we see a long way to be followed by managers, workers and users of the UHS, so that, in fact, is reached the implementation of ICP in some services and their introduction in many other of the PHC in the UHS.

CONCLUSION AND IMPLICATIONS FOR THE PRACTICE

Thematic content analysis was effective for understanding the meanings attributed by PHC service managers about the availability of ICP in the MRG. The nuclei of senses emerged in categories that showed how much the ICP are still restricted in their scope, considering a health model based on specialization and fragmentation, which implies the low and discontinuous offer of ICP.

The difficulties and insecurity of the interviewed managers/coordinators regarding the conceptualization of ICP were notorious, although they understood the context of insertion of the practices. In addition, they saw positive and negative points of its offer, considering the team's performance and attention to users. The challenges are pertinent to the need to ensure funding, train and involve managers and professionals, make available material resources and broadly and systematically disseminate ICP.

Thus, it is essential to provide more spaces for reflection on the plurality of care rationalities, including managers/coordinators, professionals and users. The purpose is to build in the health field a reality with public policies that addresses the needs and singularities of individuals, supporting decision-making that favors the development of ICP in the UHS services.

Limitation of the study is considered to be the period of data collection, since the ICP in the MRG are in the establishing and implementation phase. Another point to be clarified was the option to approach PHC services without addressing specificities in mental health care. This was justified by the essentiality of adjusting to the time predicted for data collection.

AUTHORS' CONTRIBUTIONS

Conception of research design. Data acquisition. Analysis and interpretation of data. Critical revision of the manuscript. Approval of the final version of the article. Responsibility for accuracy and integrity of content: **Leylaine Christina Nunes de Barros. Ellen Synthia Fernandes de Oliveira. Janaína Alves da Silveira Hallais.**

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