

**KNOWLEDGE AND UNDERSTANDING OF HEALTHCARE PROFESSIONALS
AND MANAGERS REGARDING INTEGRATIVE AND COMPLEMENTARY
HEALTH PRACTICES (ICHP) IN NORTHEASTERN BRAZIL**

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Highlights: (1) Knowledge about ICHP is uneven among those who make up the health sector. (2) Lack of knowledge undermines credibility and hinders the provision of ICHP in municipalities. (3) Continuing education on ICHP is a solution to overcome the lack of knowledge.

PRE-PROOF

(as accepted)

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ABSTRACT

Objective: this study's objective is to identify and describe the knowledge of health secretaries, Primary Care coordinators, and professionals who provide Integrative and Complementary Health Practices regarding the National Policy on Integrative and Complementary Health Practices. **Method:** this is a qualitative study conducted in the VI Health Region of Rio Grande do Norte, which comprises 37 municipalities. The study included 66 participants divided among health secretaries, coordinators, and health professionals. The instruments used to obtain the results were semi-structured interviews and non-participant observation. The data were analyzed using thematic content analysis. The study was submitted to the ethics committee and approved. **Result:** knowledge about Integrative and Complementary Health Practices among managers, coordinators, and health professionals is uneven, ranging from a deep understanding to a superficial or incorrect comprehension. **Conclusion:** lack of knowledge leads to misconceptions that these practices are less scientific or technical, which undermines their credibility and hinders their implementation in health services. Continuing education has strong potential to overcome the lack of knowledge and the challenges related to the provision of integrative and complementary health practices.

Keywords: Complementary Therapies; Health Management; Knowledge; Health Policy.

INTRODUCTION

Integrative and Complementary Health Practices (ICHP) are considered therapeutic resources based on natural mechanisms and the rebalancing of health, which present high effectiveness, promote comprehensive care, have low cost, and are related to cultural

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experiences. These practices are linked to the perspective of health promotion, quality of life, a more holistic view of illness, and comprehensiveness⁽¹⁻²⁾.

In Brazil, the implementation of ICHP occurred through the enactment of Ordinance No. 971 of the Ministry of Health (MH) in 2006, which established the National Policy on Integrative and Complementary Health Practices (PNPIC), regulating the provision of non-conventional knowledge and practices within the Unified Health System (*Sistema Único de Saúde* - SUS)⁽³⁾. Initially, the PNPIC regulated only five practices: phytotherapy, homeopathy, traditional Chinese medicine/acupuncture, thermalism/crenotherapy, and homeopathy. In 2017, the PNPIC underwent an expansion, adding 14 practices to its scope, and in 2018, it reached the milestone of 29 regulated practices within the SUS, aiming to provide greater benefits to health services⁽⁴⁾.

However, the implementation of ICHP as a national policy remains a challenge throughout the Brazilian territory due to several factors, such as the overvaluation of the biomedical model, limited knowledge on the subject, a small number of trained professionals due to the minimal availability of academic training on ICHP, and the lack of resources allocated to this type of practice. Therefore, all these issues result in different realities across Brazilian municipalities, with some offering and others not offering these therapeutic practices, which are so important for health⁽⁵⁾.

Knowledge about ICHP is an important aspect, considering that in the absence of resources allocated to this agenda, collective participation from all actors within the SUS is necessary to seek ways to provide these practices; consequently, it is necessary to know to seek. Studies show that the knowledge of managers and healthcare professionals about the PNPIC is low; proportionally, this directly affects the scenarios of provision observed. The population is also not very familiar with the policy; however, the practices themselves that are known are those more closely linked to Brazilian popular and religious culture. In this context, lack of knowledge becomes one of the main weaknesses to be overcome in expanding the provision of ICHP⁽⁶⁾.

Given the above, the following question emerged: what is the level of knowledge of health secretaries, Primary Care coordinators, and professionals who provide ICHP regarding the PNPIC?

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The objective of this study is to identify and describe the knowledge of health secretaries, Primary Care coordinators, and professionals who provide Integrative and Complementary Health Practices regarding the National Policy on Integrative and Complementary Health Practices.

This study is justified by the need for managers and healthcare professionals to be well-informed about the topic so that more municipalities can expand the provision of ICHP. Research that explores existing knowledge is essential to broaden this discussion and to develop solutions for the lack or low level of knowledge about ICHP and the PNPIC.

METHODOLOGY

This is a qualitative study conducted in the VI Health Region of Rio Grande do Norte (VI HR/RN), which comprises 37 municipalities, with headquarters in Pau dos Ferros. Located in the interior of the state, in a semi-arid area, the region, according to data from the 2010 Census, had approximately 35% of its population living in rural areas and economically dependent on fruit farming, cattle raising, and other natural activities⁽⁷⁾.

Several obstacles hinder full access to services in these rural areas, including political and geographical isolation, lack of accessibility, financial constraints, absence of effective planning, and ineffective public health policies, among others. Thus, the concentration of health services in large urban centers makes access to healthcare more difficult for individuals living in rural areas, resulting in a higher incidence of potentially preventable diseases and generating public health problems. The literature highlights the inability to travel as the main factor that distances the rural population from the healthcare network. In this way, access to healthcare in rural communities depends on several factors, including governmental, population, and territorial aspects⁽⁸⁾.

There are still gaps in ensuring access to healthcare for the population. It is known that those living in remote and rural areas face significant inequities, resulting in worse social and health conditions, such as low levels of education and income, in addition to difficult access to social services, healthcare, and commerce, due to territorial distances and the lack of public transportation. Furthermore, studies in several countries indicate that residents of rural areas report worse health status compared to those living in urban areas, with the main determinant

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of this health pattern appearing to be the territory itself and the challenges in accessing healthcare services⁽⁹⁾.

In this context, rural populations often resort to other ways of caring for their health, such as healing and care practices aimed at managing illness processes and strengthening health. They make use of resources such as medicinal plants, prayers, blessings, as well as the knowledge of herbalists, traditional birth attendants, and root healers, among other practices⁽¹⁰⁾.

Thus, in rural areas, greater sensitivity to health determinants is expected due to low levels of education and income, in addition to the difficulty residents face in accessing social services, healthcare, and commerce. This includes understanding the cultural influence, as well as how users think and act in favor of quality of life, recognizing the impact of social determinants on population health⁽⁹⁾. According to ⁽¹¹⁾, it is the responsibility of healthcare professionals to welcome and explain these forms of knowledge as healthcare practices. Therefore, ICHP has the potential to improve the health of people living in rural areas.

Based on this, the study participants were divided into three groups: Group 1, composed of health secretaries; Group 2, formed by Primary Health Care (PHC) coordinators; and Group 3, consisting of healthcare professionals who implement ICHP in PHC, working in the municipalities that make up the VI HR/RN. The selection of these groups was based on the understanding that secretaries and coordinators are responsible for the management and planning of actions in primary health care, including ICHP. Healthcare professionals, in turn, are directly involved in care delivery and are responsible for offering ICHP, when these are available in the municipalities.

The individuals selected for the study met the following inclusion criteria: being a health secretary, coordinator, or healthcare professional in one of the municipalities of the VI Health Region of RN, and implementing ICHP in PHC in one of these municipalities. ICHP were considered as the 29 integrative and complementary practices regulated by the Ministry of Health within the SUS. As exclusion criteria, participants who were on leave of any kind during the data collection period were considered. Participants were previously invited via email and WhatsApp, and the invitation was subsequently reinforced in person in the respective municipalities.

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The study involved the participation of 31 health secretaries, representing 83.78% of the total (n=37); 31 PHC coordinators, also representing 83.78% of the total (n=37); and 4 healthcare professionals who provide ICHP in the municipalities served. Six coordinators (16.22%) and six secretaries (16.22%) did not participate in the study, and two healthcare professionals were on leave.

For data collection, a semi-structured interview was conducted with Groups 1 and 2. The instrument used in the interviews was divided into two parts: the first addressed professional training, and the second focused on knowledge about ICHP, including participants' familiarity with any type of practice, whether they were aware of or practiced them, their beliefs regarding these therapies, and their knowledge about the PNPIC and the State Policy on Integrative and Complementary Health Practices of Rio Grande do Norte. The interview questions were developed based on the PNPIC and underwent a pre-test, which indicated no need for modifications to the script.

Data collection took place from September 2022 to March 2023. All interviews were recorded using a smartphone and conducted only in the presence of the researcher (a nurse and, at the time of data collection, a master's student in Health and Society) and the participant. The interviews were held in rooms chosen by the participants within their workplaces. There were no repeated interviews.

Subsequently, upon identifying the existence of ICHP provision in any municipality, based on the interviews conducted with health secretaries and PHC coordinators, data collection was carried out with Group 3 through semi-structured interviews and non-participant observation. It is emphasized that the professionals who composed Group 3 were indicated by the managers of the municipalities that offered these practices. To record the observations, a field diary was used, in which the characteristics of the environment where ICHP are offered, aspects of the therapies, and the researcher's impressions were noted. The observations lasted approximately one hour and also took place between September 2022 and March 2023. The researcher already had experience with the technique, acquired through previous research and training within the research group.

The average duration of the interviews was approximately 8 minutes with the Municipal Health Secretaries, 6 minutes with the PHC coordinators, and 7 minutes with the healthcare

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professionals who provide ICHP. The data collected, both from the interviews and the non-participant observation, were methodologically analyzed using Thematic Content Analysis (TCA), conducted manually, according to Bardin⁽¹²⁾. This technique is organized into three phases: pre-analysis, exploration of the material, and treatment of the results, inference, and interpretation⁽¹²⁾.

Thus, to fulfill these stages, the researcher transcribed the interviews, organized the statements according to the questions from the guiding instrument, and subsequently extracted the central ideas (recording units), observed the recording units and similarities in the statements, constructed the categories, and completed the categories and researcher's findings. Concerning the findings from the non-participant observation, these were expressed narratively throughout the results.

The data were used until content saturation was reached, with saturation defined as the constant repetition of the same ideas among participants. The transcripts were not returned to participants for comments or corrections.

The study was approved by the Research Ethics Committee (REC) of the Universidade do Estado do Rio Grande do Norte (UERN), under opinion No. 5,646,800, issued on September 15, 2022, CAAE No. 61394922.1.0000.5294.

RESULTS

Figures 1, 2, and 3 present the sociodemographic profile of the study participants, considering age group, sex, and level of education.

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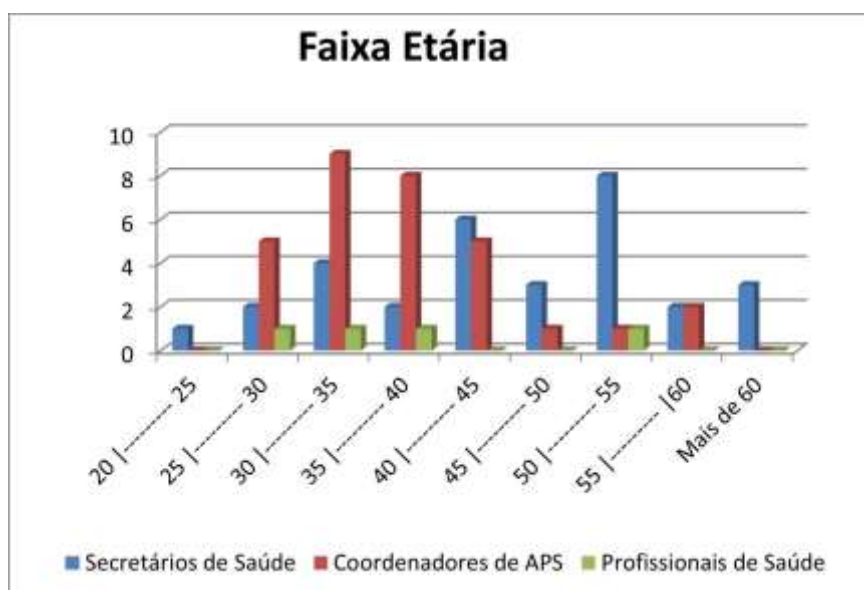


Figure 1. Age group of the study population.
Data from the author (2023).

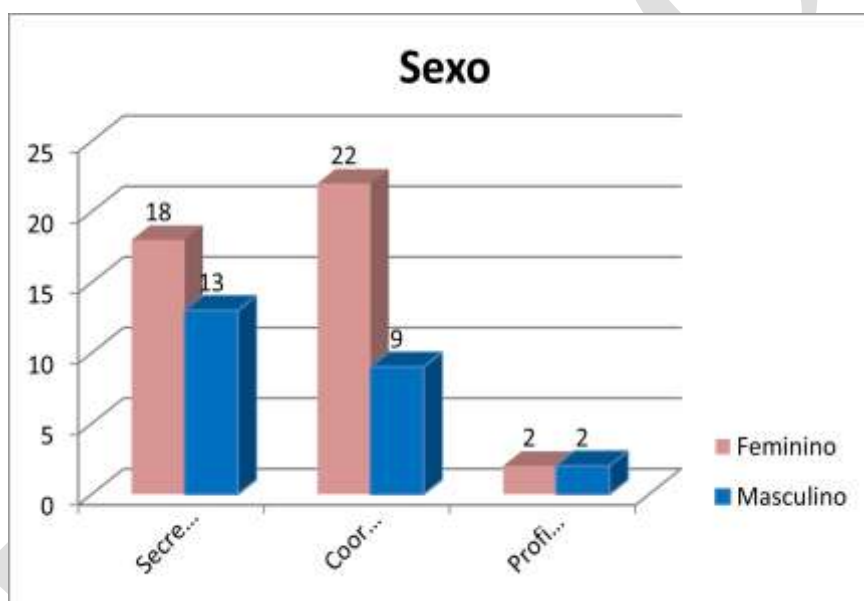


Figure 2. Sex of the study population.
Data from the author (2023).

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Figure 3. Education level of the study population.

Data from the author (2023).

Below are the final categories developed through the scaling process (initial, intermediate, and final categories) and the responses provided by participants during the interviews.

Knowledge about ICHP

(...) I am familiar with it, and I have participated in some practices, but I don't know it directly. I don't have in-depth knowledge, but I have tried it a few times here. (Health Secretary 1).

Integrative practices, in fact, from my understanding, are practices aimed at different areas that unify a theme, for example, we have a topic, in my understanding, leprosy, for example, and then several professionals work on that theme in a multidisciplinary way. (PHC Coordinator 3).

It is a second option. The therapy is very good, but there is no adherence from physicians, right? Physicians are allopathic, right? (PHC Coordinator 4).

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I am very familiar with auriculotherapy, chromotherapy, Reiki, yoga, anthroposophic medicine, aromatherapy, chromotherapy as a whole. (PHC Coordinator 23).

[...] I am not familiar [...], but there are therapies such as auriculotherapy, acupuncture, and plant-based therapies. (PHC Coordinator 24).

A way for us to expand the provision of our service, to improve quality of life, right? Because, for example, hypertensive patients take medication for hypertension, but we also add integrative practices. Especially patients with pain, which is what we work with the most, and smokers, right? Which is closely related to anxiety. We provide the medication, patches, and everything, but we also include this other part, right? Of medicine as a complementary approach alongside what is already routine, what is already in place. (PHC Coordinator 2).

ICHP are complementary activities that were introduced into primary care to support professionals who were previously part of NASF, right? Such as physiotherapists, speech therapists, and nutritionists, who ended up carrying out auriculotherapy, massage therapy, and these activities. (PHC Coordinator 11).

It is... everything more that we can offer and provide in terms of treatment to the patient, right? Everything we can add further. (Healthcare Professional 1).

Well, I don't know if that's exactly it, but they are practices that support workers' health, employees' health, and also users' health in a way, right? So... the ICHP I think of would be something like community therapy, relaxation activities, more focused on the work aspect, for the employee, you know? For the professional (...). (Healthcare Professional 3).

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Knowledge about the National Policy on Integrative and Complementary Health Practices and the State Policy on Integrative and Complementary Health Practices

I have seen it, but I haven't, how can I say, gone deeper into it or implemented it in the municipality. The state one I knew because we read it, but yes, I do know it. (Health Secretary 7).

No, and the state one, I have heard about it superficially, because, as I said, every day we receive so many ordinances, so many things... that sometimes it goes unnoticed. (Health Secretary 11).

I have heard about it, but I do not know of it. (Healthcare Professional 3).

They have never presented it. No, not to us. (Healthcare Professional 4).

I have read it very superficially, but to put it into practice in our daily routine, no [...]. The state one I already knew existed [...]. There is no training, no continuing health education, and no refresher process. (PHC Coordinator 17).

As I said, I know it superficially [...]. The state one I also know superficially, but I have never gone deeper into it. (PHC Coordinator 18).

I know it, I have read it, but only superficially; I have never really delved into it. As I told you, primary care is so full of responsibilities that this part is something we fall short on. [...] we only participate when the state calls us for something specific, and we are not able to follow through. I know there is a state policy, I know there is a regulatory ordinance about it, I also know... I just can't say, I don't remember the number, [...]. (PHC Coordinator 20).

No. I am quite unfamiliar with them. (PHC Coordinator 21).

I knew there was a state one and a national one. I have read that whole manual. During the previous administration, we implemented some of them. But since it is a small municipality, there is constant turnover of professionals. (PHC Coordinator 22).

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DISCUSSION

Based on the statements presented, it is evident that knowledge about ICHP is still uneven among healthcare managers. According to the interviews, there are managers who have only superficial knowledge, as well as those who are unaware or have an incorrect understanding of what integrative therapies are. From the reports, concerning perspectives can be observed regarding how these therapies are perceived by managers, with some descriptions referring to this type of therapy as being distant from science, or less complex, less technical, and quicker. This distorted view of such therapies undermines their essence and hinders their provision within health services.

An international study conducted by⁽¹²⁾ explains the impact of the types of knowledge about ICHP that each leader possesses and how this directly affects the provision of these practices in countries, states, and municipalities. The authors suggest that knowledge can be systemic (related to policies and bureaucracies concerning a given topic); organizational (how something is prioritized over other demands); interpersonal (taking into account personal experiences and the demands and experiences of patients); and individual (referring to one's own knowledge and beliefs). Therefore, managers who have favorable knowledge about ICHP tend to implement it.

Viewing ICHP as something distant from science reflects a significant gap in the administration's efforts to monitor scientific studies and adherence to policies that support this type of therapy at the global, national, and state levels. This gap is also evident in the statements made by the secretaries, who demonstrate a lack of knowledge of national and state policies, or only superficial knowledge of them. The lack of knowledge about these regulations is a gap that may have arisen from several factors, ranging from the workload faced by managers to the lack of training and clarification provided by higher-level institutions responsible for disseminating them.

However, it is worth emphasizing that the lack of knowledge about ICHP among managers is a phenomenon that also affects other contexts. Studies by⁽¹³⁾ show that few managers are familiar with the PNPIC, and those who do have some knowledge do not use it for decision-making in the development of policies and local implementations related to the

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topic. This attitude ultimately results in another issue, which is the low level of participation of managers regarding ICHP across different territories.

Another factor identified in the narratives that deserves attention is the belief that ICHP are associated only with mental health issues, palliative treatments, or specific chronic diseases for group activities. ICHP are therapeutic approaches that can and should be offered at different stages of life. They have effectiveness and applicability in various aspects of the human body that go beyond a restrictive use in mental health, and can be used to achieve results in physical and visceral conditions. It is also important to note that ICHP are therapies that can be integrated across all stages of the health-disease process, being incorporated in health promotion, disease prevention, and as complementary approaches to treatment.

The statements of the coordinators emphasize a more accurate understanding of what ICHP are, characterizing them as important, essential for improving health, and as a way to embrace the cultural context of the population. However, from another perspective, it is observed that even when coordinators believe in ICHP, their provision is underutilized in municipalities due to disbelief among professionals, especially physicians. It is worth noting that, according to the interviews, this professional category is one of those with the highest demand from the population and the greatest potential for prescribing therapeutic approaches.

The discussion regarding the relationship between physicians and ICHP is complex and involves layers related to entrenched professional biases, limited knowledge about ICHP, and a medical education model strongly linked to laboratory-based clinical practice, the prescription of tests and procedures, and fragmented knowledge. For a long time, medical training was also associated with the commodification of health. Fortunately, there have been changes in the National Curricular Guidelines for medical courses, and there is a movement toward greater involvement of these professionals in ICHP⁽¹⁴⁾.

Advancing the analysis, there is a recurrence of ideas already presented and discussed in the statements of the secretaries, such as the confusion between the concept of ICHP and multiprofessional work, the association of these therapies with medication reduction and mental health, and once again, the attribution of responsibility for their provision to NASF. The constant reiteration of such specific and reductionist perspectives regarding such broad therapies highlights an urgent need to re-educate management. This re-education should

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enable municipalities to first understand what IHP are, what options exist, and how best to offer them in their local contexts.

Continuing education emerges within the movement of care practices as a policy with a recognizing and collaborative nature, aiming to connect everyday encounters in healthcare work with updates, producing a combination of forces that act upon those who carry it out and promote their training, while also operating in the production of healthcare. Therefore, the implementation of this educational mechanism may lead to greater recognition and support for IHP, encouraging discovery, action, scientific research, and the incorporation of other therapies and professionals into the SUS. However, it is important to overcome the challenges related to the integration of continuing education, with its guiding principles and its full scope, into the primary care work agenda. It is necessary that there be encouragement and interest from management to achieve this⁽¹⁵⁾.

In similar contexts, where provision is also scarce or limited, this is associated with the lack of an official national coordination of the PNPIC within the Ministry of Health itself, as well as with the lack of clarity for managers on how to obtain financial resources to offer IHP. The presence of competencies such as leadership, interpersonal relationships, team motivation, and communication, in addition to knowledge itself, are important for managing public policies such as the PNPIC⁽⁴⁾.

Furthermore, it is important to emphasize that the relationship between IHP and NASF is valid, as this is a multidisciplinary mechanism aimed at expanding problem-solving capacity and providing educational and care support for issues in primary care, which includes the use of IHP. However, responsibility should not rest solely on this unit; IHP should also be offered by other professionals working in primary care. Moreover, assigning responsibility only to NASF for the provision of IHP is concerning, given the changes in funding and the existence of these centers throughout the country⁽¹⁶⁾.

Regarding the professionals' statements presented above, they reveal an interesting but, at the same time, concerning context, given that some professionals are unfamiliar with what IHP means, yet they provide these practices. It is understood that some professionals do not

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associate the practices they offer with a broader set of therapies that have their own conceptual basis, and remain unaware of the very term that designates them.

The situation becomes even more concerning from the perspective of the lack of knowledge about the National Policy on Integrative and Complementary Health Practices, as well as the State Policy that also regulates them, considering that it is expected that those who work with these therapies are familiar with them to better support their practice. The lack of knowledge about the regulatory policies of ICHP is a gap that arises from multiple sources, given that discussions about these policies could and should occur during ICHP training processes and within the work process itself, especially in municipalities that have chosen to adopt and offer this type of therapy.

The predominance of the biomedical model, the underreporting of those who apply these practices, the absence of specific subjects in undergraduate education, as well as the lack of visibility of the topic within the work environment itself, lead professionals to lack a full understanding of the breadth of knowledge encompassed by the PNPIC. Training processes must be developed so that professionals understand the PNPIC and can effectively apply it⁽¹⁷⁾.

The main difficulties encountered in conducting this study were related to scheduling conflicts with participants and the distance between the municipalities in which they work, which required more complex logistical planning. Regarding the study limitations, it is understood that the fact that it describes only one health region within a single state may be considered a limitation for generalizations. However, the study may serve as an example for further investigations into different contexts regarding the implementation of policies related to ICHP.

CONCLUSION

Knowledge about ICHP among healthcare managers, coordinators, and professionals is uneven, ranging from superficial to incorrect understanding. This lack of knowledge leads to

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misconceptions that these practices are less scientific or technical, which undermines their credibility and hinders their implementation in health services.

Such distorted views reflect a gap in management regarding the monitoring of scientific studies and the understanding of policies that support these therapies at global, national, and state levels. Work overload and the lack of training and clarification from higher-level institutions may be contributing factors to this situation.

Continuing education on ICHP is essential for healthcare professionals and managers, as it provides a deep and accurate understanding of these therapies, their applications, and benefits. This continuous and comprehensive training is crucial to demystify misconceptions, expand acceptance and credibility of ICHP, and ensure that they are effectively and safely integrated into health services. Furthermore, training managers and healthcare professionals on existing policies and regulations facilitates the implementation of strategies that promote comprehensive health, benefiting the population through diversified and complementary therapeutic approaches.

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