

ORIGINAL ARTICLE

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

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Highlights: (1) Healthcare professionals demonstrate limited knowledge of ICHP. (2) Structural barriers and a lack of awareness hinder the consolidation of ICHP. (3) To strengthen ICHP in primary healthcare, it is necessary to incorporate them into academic training.

PRE-PROOF

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**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

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ABSTRACT

Objective: to identify the knowledge that primary care health professionals have regarding integrative and complementary health practices and how these practices are provided. **Method:** A descriptive, exploratory study with a qualitative approach. Data were collected through semi-structured interviews with higher-education professionals from the core healthcare team—physicians and nurses—as well as the multidisciplinary home care and support team. The results were analyzed using Laurence Bardin’s content analysis technique. **Results:** It was found that professionals’ knowledge of Integrative and Complementary Health Practices and the National Policy on Integrative and Complementary Health Practices is limited and superficial, and that most had no prior exposure to the subject during their training, being unable to determine whether the municipality where they work offers any type of integrative practice. It was also found that the lack of training on the subject hinders the provision of these services. **Conclusion:** It is necessary to implement effective measures that promote training and investments in infrastructure and supplies so that healthcare professionals can provide high-quality care for the various practices already guaranteed by the National Policy on Integrative and Complementary Practices. **Keywords:** Primary Health Care; Integrative and Complementary Health Practices; Health Policies.

INTRODUCTION

Integrative and Complementary Health Practices (ICHP) are forms of treatment that utilize therapeutic resources and are grounded in traditional and folk knowledge focused on disease prevention and health promotion. ICHPs contribute to a broader view of the health-disease process and the promotion of care; in this healthcare practice, the individual is viewed holistically, taking into account all aspects—whether physical, psychological, social, and/or emotional¹.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

According to the Ministry of Health (MS), ICHPs are categorized by level of complexity, with 78% provided at the Low Complexity level, 18% at the Medium Complexity level, and 4% at the High Complexity level¹. Thus, Primary Health Care (PHC), as the most widespread component of the Health Care Network (RAS) and the one with the strongest ties to the community, is the level of care where ICHPs are most frequently provided, making it the preferred setting for the effective implementation of these practices².

Both in the context of PHC and ICHPs, it is evident that the measures linked to the objectives within the National Primary Care Policy (PNAB) and the National Policy on Integrative and Complementary Practices (PNPIC) share common elements, emphasizing care for the individual, family, and community, as well as the techniques used in providing this care. Thus, both policies complement each other and, together, can seek to strengthen and expand ICHP within PHC³.

Public health policies are planned, promoted, and implemented at the federal, state, or municipal level by health managers and professionals. The SUS is the State's primary public policy for guaranteeing the right to health and represents the largest social inclusion policy for the Brazilian people⁴. Consequently, the importance of ICHP for strengthening the SUS is evident, as they expand care options and promote comprehensive and humanized care, contributing to improved quality of life for users. Furthermore, by being incorporated and encouraged within PHC, ICHP benefit not only users but also professionals, generating positive impacts such as greater satisfaction and a sense of fulfillment in the practice of care⁵.

Among the numerous public policies developed within the scope of the SUS is the PNPIC, established by Ministry of Health Ordinance No. 971 of May 3, 2006. The policy addresses institutional guidelines and responsibilities regarding the provision of services and products in homeopathy, traditional Chinese medicine/acupuncture, medicinal plants, and phytotherapy, in addition to establishing observatories for anthroposophic medicine and social thermalism/crenotherapy, thus comprising five ICHP in its initial guidelines⁷.

Furthermore, the policy underwent two modifications—an expansion in 2017 and another in 2018—and currently offers a total of 29 ICHP to the population, free of charge and fully covered by the SUS, which together aid in disease prevention, palliative care, and health promotion through traditional knowledge¹.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

However, even though an institutionalized policy has been in place since 2006, the level of knowledge among health managers and professionals regarding the PNPIC and ICHP varies across different regions of Brazil. Although recognized by the World Health Organization (WHO) and included in the PNPIC, many professionals are unaware of their use, benefits, and scientific evidence, which leads to gaps in service provision⁸.

Therefore, given this context, the following question arose: What is the level of knowledge among health professionals regarding the PNPIC and ICHP within the context of Primary Health Care (PHC) in a municipality in the interior of Rio Grande do Norte? How are ICHP provided in the municipality in question?

To answer this question, this study aimed to identify the knowledge that primary care health professionals have regarding Integrative and Complementary Health Practices and how these practices are provided.

METHOD

This is a descriptive, exploratory study with a qualitative approach. The present study was conducted in the city of Pau dos Ferros, Rio Grande do Norte, a municipality located in the interior of the Northeastern Semi-Arid Region, which, according to the Brazilian Institute of Geography and Statistics (IBGE)⁹, covers an area of 259,959 km² and has an estimated population of 30,479 inhabitants, with a population density of 117.25 inhabitants/km², located approximately 400 km from the state capital.

The study participants were health professionals with higher education who comprise the core health team (nurses and physicians) working at the UBS, and professionals from the municipality's multidisciplinary home care and support team (dietitian, occupational therapist, psychologist, physical therapist, physician, and nurse), totaling 33 individuals.

Of the professionals eligible to participate in the study, we had three refusals, five absences due to sick leave, vacation, and/or other reasons, while three others met the exclusion criterion of having less than two months of experience.

A total of 22 interviews were conducted with professionals holding a college degree, including physicians, nurses, and members of the municipality's multidisciplinary teams, specifically the Multidisciplinary Home Care Team (EMAD) and the Multidisciplinary Support Team (EMAP). For the purpose of selecting participants, the following inclusion criteria were

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

applied: working as a healthcare professional with a college degree, as a member of the minimum Family Health Program (ESF) team assigned to a Basic Health Unit (UBS) in the urban area of the municipality; or working as a healthcare professional with a college degree as part of the multidisciplinary healthcare support team for the UBS. The following exclusion criteria were considered: being on leave from duties due to vacation or leave of any kind; or having less than two months of experience in the role.

Data collection was conducted through a semi-structured interview, which included questions regarding the participant's background, required and elective undergraduate courses on ICHP, and their knowledge of Integrative and Complementary Health Practices. The interviews were conducted in person by one of the study's researchers. Initially, the nine Basic Health Units were visited to present the project and distribute the Informed Consent Form (ICF) and the Authorization for Audio Recording Form (AARF), allowing a seven-day period for participants to agree to participate. After acceptance, the interviews were pre-scheduled according to the professionals' availability and conducted individually in a setting chosen by the participants, ensuring privacy, confidentiality, and comfort.

The identities of the study participants were protected by coding the interviews. Thus, they were designated and classified as Participant 1, Participant 2, Participant 3, and so on, according to the order in which the interviews were conducted. Data processing was conducted using the Content Analysis Technique (CAT) proposed by Laurence Bardin¹⁰, which consists of three stages: pre-analysis, carried out in four steps: skimming the material, selecting what will be analyzed, formulating hypotheses and objectives, and developing indicators based on text excerpts. During the exploration of the material, the data is coded, broken down, and listed. Finally, in the processing and interpretation stage, the results are analyzed and interpreted in light of the theoretical framework.

The study was approved by the Ethics and Research Committee (CEP) of the State University of Rio Grande do Norte (UERN) with opinion No. 6,529,667, issued on November 24, 2023, CAEE No. 75061123.0.0000.5294.

RESULTS

Data collection took place between December and January (2023–2024), using semi-structured interviews with a sample of 22 participants, including 18 from the core healthcare

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

team (nurses and physicians working in Primary Health Care Units) and 4 from the multidisciplinary support and home care teams (dietitian, occupational therapist, psychologist, physical therapist, and nurse).

The following data present the sociodemographic profile of the health professionals participating in the study, providing information on age, sex, marital status, and education level.

Twenty-two health professionals participated in the study. The predominant age group was 31 to 35 years, followed by the 26 to 30 and 41 to 45 age groups. Older age groups were less common. Regarding gender, a balanced distribution was observed. As for marital status, the majority reported being single, followed by those who were married or in a stable relationship. With regard to place of residence, most participants live in the municipality of Pau dos Ferros.

With regard to educational background, most participants had completed a specialized program, followed by those who had completed a bachelor's degree and those who had completed or were currently pursuing a master's degree. No participant reported having a doctoral degree or an incomplete higher education.

Regarding Integrative and Complementary Practices, 20 did not have any required courses in college, while two had one required course (homeopathy and public health), one took an elective course (acupuncture), and only two took courses in the field of ICHP, namely: ventosotherapy and acupuncture; finally, 21 of the participants did not take any elective courses during their undergraduate studies.

Based on the coding units identified in the interview transcripts, the data were initially organized and coded, resulting in 39 initial categories that represent the most recurrent themes and meanings in the participants' statements. Next, through a process of thematic grouping and analysis of convergences and divergences among the codes, these gave rise to 6 intermediate categories, each accompanied by a guiding concept derived from the interview data and the scope of the research. After organizing the participants' statements, which highlight the most relevant core meanings, it was possible to develop a deeper understanding of the phenomenon under investigation and categorize them, resulting in 3 final categories.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

Table 1 - Final categories based on interviews with healthcare professionals

GUIDING CONCEPT	FINAL CATEGORIES
Health professionals' knowledge of ICHP and PNPIC is influenced by the barriers identified in the training process	Health professionals' knowledge of Integrative and Complementary Health Practices (ICHP), the National Policy on Integrative and Complementary Health Practices (PNPIC), and professional training.
There is limited awareness of what is actually done in PHC regarding ICHP, but there is an understanding of the outcomes and potential of such practices.	The implementation of Integrative and Complementary Health Practices (ICHP) in Primary Health Care (PHC) and professionals' perceptions.
For professionals, there are both challenges and opportunities in implementing ICHP in PHC, and continuing education has emerged as a pathway to possibilities.	Potential and weaknesses for the implementation of Integrative and Complementary Health Practices (ICHP) in Primary Health Care (PHC).

Source: From the authors, 2024.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

Table 2 - Healthcare professionals' knowledge of Integrative and Complementary Health Practices (ICHP), the National Policy on Integrative and Complementary Health Practices (CHP), and professional training

Participant 2	“Not yet.”
Participant 10	“I know a little about it. The Ministry of Health’s manuals and the Ministry of Health’s website.”
Participant 22	“I’m familiar with it, though not in depth, but I do have some knowledge. So, on TV, I actually really enjoy reading about it, because I use essential oils a lot myself, and I’m quite curious, so I like to study it a lot.”
Participant 3	“Yes [...] in fact, many professors recommended it; I had a professor who specializes in pain management and practices acupuncture himself, and he had very good results, even for anxiety, migraines, and rheumatic diseases.”
Participant 8	“Yeah, just the things I mentioned—homeopathy, acupuncture—but just a general overview, nothing too specific.”
Participant 22	“No, back when I was in college, we didn’t have that.”
Participant 3	“They’re, for example, methods that help treat certain comorbidities—not so much in preventive treatment, in primary or secondary prevention, but even in rehabilitation. For instance, there’s homeopathy, which we studied well, as well as aromatherapy, chromotherapy, and things like that.”
Participant 15	“Yeah, these practices are important ones that should be developed in primary care, especially since they’re therapeutic approaches that don’t involve medication and would really help the population—but unfortunately, here in our city, they haven’t been implemented.”

Source: From the authors, 2024.

Table 2 shows that professionals' knowledge of ICHP, the concept, and the PNPIC is somewhat limited and superficial, with many not even being familiar with ICHP prior to the study. In addition, many mentioned that they had not taken any related courses—whether required or elective-during their undergraduate studies.

When asked what they understand by ICHP, the professionals report that these are practices that aid in the treatment of patients and that can be implemented in primary care.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

However, misconceptions regarding these practices were identified, such as confusion between types of ICHP, limiting their use solely to occasional therapeutic interventions, or associating them exclusively with individual professional initiatives, which highlights gaps in education and training for the effective implementation of these practices.

Table 3 - The implementation of Integrative and Complementary Health Practices (ICHP) in Primary Health Care (PHC) and the perceptions of health professionals

Participant 17	“No, as I said, nothing on the regular schedule—just occasional things. [...] The doctor even did some work—our team’s doctor [...]—something very specific, actually, related to his specialty, which was herbal medicine and herbal therapy for patients with hypertension. He brought in and provided [...] teas, if I’m not mistaken, and spices; he also brought in natural remedies and offered them to patients with hypertension.”
Participant 4	“Here at the clinic, what I really like to use is herbal medicine, because I see that many patients come in with a complaint, and often an herbal remedy [...] does much more good than harm [...] we see that there are many herbal remedies that are even more effective than over-the-counter medications, so it’s something I use a lot.”
Participant 9	“No, no, because we don’t actually have the opportunity to implement it; it involves a whole range of situations and systems—it doesn’t depend solely on us [...] we’d have to coordinate with various departments, groups, [...] the health department, other collective entities as well, and other professionals—and so it doesn’t depend solely on us. It would be interesting, but unfortunately, it doesn’t depend solely on us.”
Participant 21	“Yes, prescribing teas.”
Participant 22	“[...] at the clinic where I work and treat autistic children, there I use essential oils in therapies, both in the [...] diffuser, and I also apply the oil directly on them at times.”
Participant 11	“Without a doubt, and not just for the user, but even for management itself, because from what I hear, it doesn’t require such a high investment of resources, so I think that in addition to bringing benefits to users, it would also be a way to reduce costs—whether for medications or a range of other things—but unfortunately, we don’t have that here yet.”
Participant 15	“Definitely, there are many benefits: it would reduce the amount of medication needed, it could alleviate pain without relying on medication,

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

	and it allows you to engage in physical and psychological exercise or relaxation—so there are many benefits.”
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Source: From the authors, 2024.

In Table 3, of the nine units and multidisciplinary teams surveyed, none of the interviewees could state with certainty whether ICHP was offered. Of the two units that mentioned it, one reported not knowing whether it was offered but believed it was, and the other reported that it had happened once, due to a specialization course the unit’s physician was taking.

When asked what they most liked to use, recommend, or prescribe for their patients, the professionals emphasized herbal medicines and the use of essential oils. Despite the lack of implementation, everyone recognizes that the introduction of ICHP in PHC could bring numerous benefits, including a reduction in medication use and lower costs for other treatments.

Table 4 - Strengths and weaknesses in the implementation of ICHP in primary health care

Participant 1	“I think the biggest challenge would be training people—the professionals. Once they’re trained, we’d be able to offer and provide this service. First, we need to show professionals that this approach exists, this way of providing the service; after that, train them, and then provide the basic infrastructure—which I don’t think would be the biggest problem. It’s really more about offering and promoting this service.”
Participant 11	“Actually [...] I see a difficulty because there’s a lack of training for professionals. I think that if we had that training, maybe we would have already implemented it, and so, I recognize that these practices have a distinct advantage, because I see colleagues who use them and report improvements; ultimately, the lack of training is what prevents us from actually putting them into practice [...].”
Participant 5	“Yes, first access. When I say access, it’s a matter of availability; second, patient resistance to understanding that some approaches are truly therapeutic, health promotion, and prevention. I think there’s a lot of resistance—perhaps it’s cultural too—people don’t understand certain aspects; they think only drug therapy will solve the problem, in short.”
Participant 15	“[...] The population wouldn’t understand that this would be a benefit, partly because we have a very medication-focused practice, where for them, only medication cures disease.”

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

Participant 20	“No, because they’re inexpensive, they’re accessible, the cost-benefit ratio is very favorable, there’s no difficulty [...] The difficulty I see is that there are many people who aren’t familiar with them, and they’re a bit wary; sometimes they don’t believe in the ICHP I use as a professional.”
Participant 22	“No, it’s not difficult at all; I just don’t think it’s highly valued or very well known in reality. No, I think that if there were more courses and training programs, it would really help with implementation.”
Participant 4	“The accessibility [...] a very community-oriented, very open environment, a gateway—it would be great to have this kind of practice here, because people come, they have no trouble accessing it, and having someone who could perform the procedure, a practice like this, would be very welcoming for them.”
Participant 9	“Definitely, even for my own knowledge, because I feel a vast amount of knowledge even within this interview you’re conducting with me, because we end up having limited knowledge [...] when we aren’t in the habit of practicing [...] so it would certainly be of great benefit, not only for us as professionals, but also for our users; so for me, facing an interview like this, it even highlights the need to study further, to deepen my knowledge in this area.”
Participant 1	“It was a very good experience, [...] I do it regularly because I suffer a bit from lower back pain, pain in the spine, partly due to my profession—spending a lot of time sitting, a lot of time in the same position—and sometimes I turn to this therapy to help relax my muscles and the spine area [...].”
Participant 14	“Yes, in my case, since my brother is a healthcare professional and back when I was in school, I was there working on my thesis, in the midst of my internship, and I told my brother about it, and then he did auriculotherapy on me and I felt great [...] I really liked it.”

Source: From the authors, 2024.

In Table 4, participants mention that one of the obstacles to implementing ICHP in primary health care is related to a lack of training, given that these practices require information technologies⁷ and low-cost materials. Furthermore, the interviewees themselves have, at some

⁷ In the field of healthcare, the term “information technology” refers to the use of digital systems, software, databases, and communication networks that allow the storage and processing of digital data, as well as the access to information, and remote communication, thereby promoting integration among professionals, services, and users. These technologies support the management, care, and production of knowledge within the Unified Health System.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

point in their lives, benefited from the use of ICHP, demonstrating that the implementation and use of these technologies bring benefits to everyone.

DISCUSSION

The relationship between the training process, knowledge, and the offerings of ICHP.

The integration of ICHP into health systems has become an increasingly central topic in national and international discourse, driven in particular by the advancement of policies proposed by the World Health Organization (WHO) and by the growing social demand for expanded approaches to care. Globally, the WHO Strategy for Traditional, Complementary, and Integrative Medicine 2025–2034, adopted by the 78th World Health Assembly, envisions a world where everyone has universal access to person-centered traditional medicine aimed at promoting health and well-being in a qualified and comprehensive manner. Thus, this strategy establishes guidelines for improving the quality-of-care delivery, strengthening regulation, and integrating ICHP into healthcare networks, emphasizing the need for evidence, governance, and continuous monitoring¹¹.

In Brazil, as mentioned earlier, the policy supports the provision of 29 practices,¹ including approaches ranging from mind-body therapies to traditional medical practices. More recent reports from the Ministry of Health point to an expansion of services, the strengthening of training centers, and advances in national monitoring, even though regional inequalities and challenges related to institutionalization, funding, and professional qualifications remain¹².

At the state level, significant heterogeneity is observed. Some states, such as Rio Grande do Norte, have instituted robust policies that guide the implementation of ICHP at all levels of care, with clear and well-established guidelines. Others, for example, such as the state of Ceará, have more restrictive frameworks, limited to herbal medicine,¹³ highlighting that there are many disparities in the consolidation of these practices. These divergences ultimately show us that the expansion of ICHP depends as much on state-level standardization as on municipal engagement.

Brasil, Ministério da Saúde; Universidade Federal do Rio Grande do Sul. Manual de Telessaúde para a Atenção Básica/Atenção Primária à Saúde: Protocolo de Solicitação em Teleconsultorias. Brasília (DF): Ministério da Saúde, 2013. Rodrigues RB. Novas Tecnologias da Informação e da Comunicação. Recife: IFPE, 2016.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

In this context, according to the PNAB and the Ministry of Health (MS), PHC serves as the primary means for implementing ICHP within the SUS¹⁴. This is because PHC is intended to function as the entry point for users through the Health Care Networks (RAS).

To establish mutual care between ICHP and PHC, it is necessary to consider various processes involved, ranging from policy, management, human resources, supplies, and cultural processes within the workplace itself, among others. Furthermore, professionals should be encouraged by health services and public health policies to broaden their vision of care, understanding that the biomedical model is not the only solution to health problems, but that ICHP can work together in this care¹⁵.

Although progress in health-related programs is widely recognized, higher education in Brazil remains deeply rooted in a physician-centered approach. Despite the fact that ICHP are presented as a public policy established by the SUS, as well as in the state of Rio Grande do Norte, the Pedagogical Projects of Health Undergraduate Programs (PPHUPs) at universities located in Rio Grande do Norte offer only 5% in a mandatory format, 5% restricted to the Curricular Component (CC) on therapeutic processes, 70% in an elective format, and 20% in pedagogical projects¹⁶. In other words, the majority of ICHP content is offered in the elective component, leaving it up to the student's discretion or curiosity to seek out and learn more about ICHP.

Based on the average age of the participants, it is evident that PNPIC had already been integrated into the healthcare system; however, it was rarely addressed in undergraduate education. The data showed that only two of the participants had required courses on the subject during their undergraduate studies, indicating that this area is still rarely discussed in academic settings and is also rarely offered. One of the PNPIC guidelines emphasizes the promotion of research on ICHP and the inclusion of courses in undergraduate and graduate programs; in other words, this is something that is already established but requires administrative and institutional support to be incorporated into university curricula⁶.

Among the numerous problems surrounding the integration of ICHP into PHC, one may be linked to the fact that professionals feel insecure about passing on their knowledge of these practices through Popular Health Education (PHE), given the lack of technical training among professionals to implement them¹⁷.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

EPS serves as an excellent tool for disseminating and implementing ICHP, facilitating the integration of traditional, social, and professional health knowledge. Thus, these conversations between users and PHC professionals contribute to these dialogues, while also sharing knowledge and valuing the wisdom of the community¹⁸.

The relationship between management and the process of building knowledge about ICHP for professionals.

Some of the challenges identified by healthcare professionals revolve around resource allocation, organizational issues, and management support. Participants reported possible resistance from patients to the introduction of these new practices, given that they represent a new therapeutic approach¹⁹. However, the use of these practices can help reduce the overuse of medications, as they are low-cost, accessible, and focused on health promotion and comprehensive care for users⁶.

The implementation of ICHP in PHC is a way to improve the services provided by health units, promoting expanded access and enhanced service quality, since all users would have the opportunity to benefit from these practices within a comprehensive care framework²⁰.

The incorporation of these practices into primary health care has led to successful outcomes, with positive results for both patients and health care professionals and service administrators. The literature indicates that ICHP has positive effects on improving physical and psychological symptoms, such as pain, anxiety, stress, and insomnia, primarily through the use of acupuncture, herbal medicine, massage therapy, and meditation²¹. Furthermore, these practices help strengthen the bond between staff and the community, making care more centered on users' health needs, while also contributing to comprehensive care and health promotion²².

Despite the identified benefits, the implementation of these initiatives still faces significant obstacles, such as a lack of investment—particularly structural factors—as well as a shortage of supplies, adequate workspaces, and the materials needed to expand, consolidate, and effectively implement these practices in healthcare facilities. Therefore, the effective implementation of these practices requires not only political recognition but also the provision of resources and materials to ensure their expansion, as well as the creation of public policies that guarantee the training of professionals qualified for the various practices offered by the policy²³⁻²⁴.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

Next, another major difficulty mentioned is associated with training professionals to perform these ICHP effectively in PHC. Training should be provided by the federal or municipal government or by the professional association. However, when training is not available in the public sector, professionals must turn to the private sector, financing their own training to become qualified in specific ICHP²⁵.

This situation could be addressed if the health services management team, in collaboration with the Municipal Health Department and educational institutions, developed and implemented outreach and continuing education initiatives on ICHP, so that such education becomes easier and more accessible to all professionals interested in training and enhancing their knowledge on the subject²². Considering that high-quality and efficient continuing education opportunities improve work processes, and when focused on learning about ICHP, they enrich patient care and strengthen a holistic approach to healthcare²⁶.

The National Policy on Continuing Education (PNEPS) was conceived in 2003 and has been updated over the years with new proposals aimed at improving health services. Its underlying principle is that it is necessary to seek knowledge to solve the day-to-day problems of healthcare work. Thus, continuing education takes place collectively, where professionals learn about themselves, about others, and build relationships with others. In this way, continuing education is structured as work-based learning, applicable to understanding different contexts²⁷.

Finally, the study had some limitations, such as difficulties in contacting the entire pre-determined sample of professionals (n = 33), which may have ultimately limited the results and the experiences analyzed. This limitation can be overcome by adopting new strategies aimed at expanding communication channels with the professionals to be interviewed or even by using digital forms, thereby facilitating the collection of more diverse responses and a larger number of participants. In addition, it is also possible to establish institutional partnerships, enabling researchers to more easily contact professionals willing to assist with the research in future interviews.

**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

CONCLUSION

It became evident that healthcare professionals working in primary care have limited knowledge of what Integrative and Complementary HHPs are, what their benefits are, and how to incorporate them into this setting.

Given the above, in order to organize health services and ensure compliance with established policies, it is necessary to implement effective measures that promote training so that health professionals can provide the various practices already guaranteed by the PNPIC with high quality. This will enhance professionals' knowledge and improve the quality of services provided to users.

Therefore, for ICHP to be effectively integrated into the SUS, consistent financial investment is needed, along with the institutionalization of these practices, ensuring the material and organizational conditions necessary to sustain their continuity and quality, in order to expand access, ensure equity, and consolidate their role in comprehensive health care.

This study revealed that there is little recognition or encouragement for the application of ICHP, particularly in the context of primary health care. Therefore, it is important that topics such as these be further explored and debated across all fields, including in academic settings, given that future health professionals will already possess knowledge of the National Policy on Integrative and Complementary Health (PNPIC) and ICHP, in light of their scientific relevance.

The objective of this study was achieved, as it enabled us to assess the knowledge of healthcare professionals working in Primary Health Care regarding Integrative and Complementary Health Practices.

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THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

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**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

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**INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES:
THE PERSPECTIVE OF PRIMARY HEALTH CARE PROFESSIONALS**

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