

The Implementation of Integrative and Complementary Health Practices in the State of Rio Grande do Sul, Brazil

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Abstract— This study aims to describe the implementation of the Integrative and Complementary Health Practices (PICS) in the state of Rio Grande do Sul, located in the extreme south of Brazil. It uses the norms related to the National Policy of Integrative and Complementary Health Practices (PNPIC) and the State Policy of Integrative and Complementary Practices of Rio Grande do Sul (PEPIC / RS) in addition to other government documents and published papers reports on policies for describe this process that started in 2006 with the publication of the PNPIC. The main results include the standardization of twenty-nine PICS within the scope of Unified Health System (SUS) and the preparation of a manual for their implementation, in addition to the preparation of nine Technical Notes in Rio Grande do Sul as a way to encourage municipal managers to bid the PICS. There are still difficulties facing the dissemination and financing of these practices.

I. INTRODUCTION

The Brazilian national health system respects three constitutional principles (universality, integrality and equity), being structured through a network of regionalized and hierarchical health services and actions, with additional participation from the private network and free of charge to the end user. There are a series of national policies focused on comprehensive care by life cycle (eg: National policy for comprehensive health care for children and adolescents, the elderly; women, men), with specific care programs (eg: the National Pharmaceutical Assistance Program for Hypertension and Diabetes Mellitus, part of the National Plan for Attention to Hypertension and Diabetes Mellitus) [1,2,3].

The National Policy of Integrative and Complementary Health Practices (PNPIC) was regulated in 2006, following the approval of Ordinance number 971/2006 of the Ministry of Health. The elaboration of this policy is the result of a wide debate involving questions

about the integration of traditional medicine to the health system and guarantees of safety and effectiveness of such practices [4].

The use of Complementary Therapies has always been present in the daily life of the population that uses traditional practices, such as teas, acupuncture, homeopathy and herbal medicines [5]. However, these practices have always been on the margins of the public health system. Thus, PNPIC was created to include traditional practices to the Unified Health System (Brazilian public national health system - SUS), respecting its principles and objectives.

According to the text published in 2006 and updated in 2015, the PNPIC aims to guarantee integrality in health care by supporting the experiences that had already been developed in the public health network [4]. In addition to political, technical, economic, social and cultural issues appearing in the policy justification, the symbolic character of regulating such practices must be

emphasized. Something that had already been recommended by the World Health Organization (WHO) from the document Strategies for traditional medicine 2002-2005 [6].

Some recent data shows how the PICS have gained visibility and acceptance. For example, the number of collective activities, such as yoga and tai chi chuan, went from 216 thousand to 315 thousand activities in Brazil between 2017 and 2018 [7]. Approximately one third of patients with a history of cancer used Complementary Therapies between the years 2018 and 2019, the most frequent being: herbal supplements, osteopathic manipulation chiropractic, massage, yoga, tai chi chuan, mantra, mindfulness and spiritual meditation - 29 % of these patients not reporting the use of these therapies to their doctor [8].

However, despite its regulation having occurred 15 years ago, its actions are still unknown to a large part of the population, although many people routinely employ some therapies regulated by the aforementioned policies. For example: a study carried out in the city of Montes Claros (State of Minas Gerais), shows that around 70% of families used popular practices such as prayers, blessings, folk remedies and body practices [9]. That is, even using Complementary Therapies, the population is not aware of these therapies through the public health system.

Professional training, health system management and conceptions centered on the biomedical paradigm [7] are obstacles to the implementation of integrative and complementary practices in the health system, even in Primary Care, when some practices are offered without disclosure and at the initiative of the professional [10].

Considering the importance of PICS in the scope of public policies, this article intends to present the process of construction and implementation of the National Policy of Integrative and Complementary Health Practices (PNPIC), and its version in the state of Rio Grande do Sul - State Policy of Integrative and Complementary Health Practices of Rio Grande do Sul (PEPIC-RS).

II. METHODS

Brazil is divided administratively into 26 states and the Federal District. The state of Rio Grande do Sul is located in the southern region, at its extreme, comprising 497 municipalities and an estimated population of 11.4 million inhabitants for 2020 [11]. To this end, this state is responsible for designing actions to implement PICS in its territory.

This article describes the implementation of the National Policy of Integrative and Complementary Health Practices (PNPIC) and the State Policy of Integrative and Complementary Health Practices of Rio Grande do Sul (PEPIC / RS). For that, a descriptive analysis of such policies will be carried out through the documents referring to them as well as other works that describe their effects after 15 years of implementation of both.

It is an intrinsic case study [10] since, when choosing the case of the PNPIC implantation and its development in Rio Grande do Sul, there is an interest in understanding this case in its particularity.

The documents regulating the PNPIC [12–15] and PEPIC / RS [16,17] were consulted, as well as the websites that disseminate these policies and related academic works.

III. THE NATIONAL POLICY OF INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES (PNPIC) CONSTRUCTION PROCESS

The PNPIC construction process reveals a wide technical and political discussion that permeates the health issue. Three National Health Conferences prior to 2006 are cited in the PNPIC text as a way of explaining the demand and the social legitimation of such practices, so that they could be incorporated into SUS [4]. These are: the 1st National Conference on Health Surveillance (2001), the 1st National Conference on Pharmaceutical Assistance (2003) and the 2nd National Conference on Science, Technology and Innovation in Health (2004).

From a meeting of the Minister of Health with representatives of the national associations of Phytotherapy, Homeopathy, Acupuncture and Anthroposophical Medicine, a working group was formed in 2003 to discuss and implement actions in order to elaborate a national politics. Subsequently, working subgroups were created, according to the specificities of the areas. The subgroups functioned independently, with the support of various sectors of the Ministry of Health as well as associations related to practices, using the development of national forums for the broad participation of organized civil society, technical meetings, WHO documents, among other strategies to, at the end, consolidate a technical document for national policy [4].

Among the activities developed by the subgroups, a situational diagnosis was carried out by sending 5,560 questionnaires to all state and municipal health managers, in order to identify the experiences that were being developed in the public health network in

relation to traditional practices. From the responses of 1,340 questionnaires, it was identified that 232 municipalities had these structured practices and, among these, 19 of the 26 state capitals [4]. The responses pointed to the presence of some practices that later became part of the policy, including acupuncture, homeopathy, anthroposophical medicine, phytotherapy and crenotherapy.

These practices were previously regulated by the Interministerial Commission for Planning and Coordination (Ciplan) and by specific institutions such as the Federal Council of Medicine, Pharmacy and Veterinary Medicine. In addition, acupuncture and homeopathy were included in the Outpatient Information System (SIA / SUS) in 1999 [4].

After the diagnosis made by the working groups, confirming the use of the aforementioned therapies, the document - until that moment called National Policy on Natural Medicine and Complementary Practices - was finalized and evaluated by the Technical Chambers of the National Councils of State and Municipal Health Secretaries and agreed by the Tripartite Inter-Management Commission. In September 2003, this document was presented to the National Health Council (CNS) and submitted to the Sanitary and Pharmacoepidemiological Surveillance Commission for evaluation and recommendations. After modifications, the document returned to the CNS, which appointed a subcommittee to discuss and prepare the final proposal to be evaluated again by the Council. The proposal was approved in February 2006, consolidating the National Policy of Integrative and Complementary Practices in SUS, already with this name, published in ordinances No. 971 and No. 1,600, respectively in May and July 2006 [4,12,13].

Ordinance No. 971/2006 instituted the National Policy of Integrative and Complementary Practices (PNPIC) in SUS, approving the therapies: Traditional Chinese Medicine-Acupuncture, Homeopathy, Medicinal Plants and Phytotherapy, and Social Thermalism or Crenotherapy [13]. Ordinance n° 1,600 / 2006 acts as a complement to the previous one, creating the Observatory of Anthroposophical Medicine Experiences in SUS, as a way to develop appropriate methodology and informative materials for this practice [13].

The Ministry of Health, from the publication of these ordinances in 2006, regulates the implementation of actions related to PICS and recommends the adoption of these practices to the Health Departments of the states, the Federal District and the municipalities.

In view of the objectives of the PNPIC, specific guidelines and processes necessary for the implementation of each of the practices in the health system were developed [4]. The guidelines contemplate particular aspects of each PICS, but there are common points related to the ways of hiring and training professionals, access by the population, monitoring and evaluating the insertion of these practices. Among its guidelines is the strengthening of existing initiatives, the establishment of financing mechanisms and actions aimed at training professionals, as well as the encouragement of research in PICS. However, the guidelines do not determine how states and municipalities should do this. They only suggest the need to create the standardization of procedures to enable the financing, training of professionals and the evaluation of this policy. Thus, it is up to municipal and state managers to specify the actions to be taken in their area of expertise.

Ordinance No. 971/2006 [12] also defines the institutional responsibilities of the federal, state and municipal managers, which are similar, varying only the level of breadth of their actions. These actions at the federal level are intended to foster, regulate and monitor national policy. State managers, on the other hand, are responsible for defining implementation strategies, articulating the actors and monitoring the policy in their respective states, just as it is for municipal managers to articulate these actions in their municipalities.

The main contribution of Ordinance No. 971/2006 is to support state and municipal managers who intend to implement PICS [12]. However, this implementation requires, in addition to this support, financial resources, trained professionals and structure that many states and municipalities do not have. The National Policy does not guarantee these resources, much less trained professionals, which would require changes in the undergraduate curricula of health professionals. Gatti et al. [18] revealed that, despite the approval of the ordinance that inaugurated the PNPIC in 2006, even in 2015, educational institutions had not been presenting pedagogical projects that favored the holistic view of the patient and there was a shortage of scientific works that explained its use.

Despite this, some studies show an increase in the use of Complementary Health Practices since 2006. As for example Telesi Jr [19], when showing that the number of health units in the São Paulo Health Department that offer meditation has increased from 45 in 2006 to 85 in 2015. According to the Implementation Manual of Services of Integrative and Complementary Practices in SUS [20], 8,200 basic health units (19% of the total) offered some PICS in 2017, so that these practices were

present in 3,018 municipalities (54% of the total) and in 100% of the capitals. The Ministry of Health itself points to an increase in the number of acupuncture consultations, with more than 850 thousand sessions being held in 2012 and, in 2013, 908 establishments registered to offer this practice [21]. Another relevant data points out that in 2016 there were 2,203,661 individual visits in PICS and 224,258 collective activities, which involved more than 5 million people [22].

Eleven years after the creation of PNPIC, which until then included five practices, in March 2017 the Ministry of Health approved Ordinance No. 849 [14], which includes fourteen other health practices: Art Therapy, Ayurveda, Biodanza, Circular Dance, Meditation, Music Therapy, Naturopathy, Osteopathy, Chiropractic, Reflexotherapy, Reiki, Shantala, Integrative Community Therapy and Yoga. In this document, the Ministry states that PNPIC has promoted an increase in the use of Integrative and Complementary Health Practices since 2006. In addition, the Ordinance justifies that the fourteen practices included would already be present in the health service, according to the second cycle of the National Program of Improvement in Access and Quality

Table 1: List of ordinances and practices included in the National Policy of Integrative and Complementary Practices (PNPIC)

Ordinance No.	Practices	
Ordinance No. 971, of May 3, 2006 [12]	1. Traditional Chinese Medicine - Acupuncture	
	2. Medicinal Plants and Phytotherapy	
	3. Homeopathy	
	4. Social Thermalism / Crenotherapy	
Ordinance No. 1600, of July 17, 2006 [13]	5. Anthroposophical Medicine	
	6. Art Therapy	
	7. Ayurveda	
	8. Biodanza	
	9. Circular Dance	
	10. Meditation	
	11. Music therapy	
	Ordinance No. 849, of March 27, 2017 [14]	12. Naturopathy
		13. Osteopathy
		14. Chiropractic
		15. Reflexotherapy
		16. Reiki
		17. Shantala
		18. Integrative Community Therapy (ICT)
		19. Yoga

in Primary Care (PMAQ) [22], but were not regulated by SUS.

Almost a year after the expansion of the PNPIC, the Ministry of Health includes ten more practices to this Policy through Ordinance No. 702 of March 21, 2018: Aromatherapy, apitherapy, bioenergetics, family constellation, chromotherapy, geotherapy, hypnotherapy, laying on of hands, anthroposophical medicine / anthroposophy applied to health, ozone therapy, floral therapy and social thermalism / crenotherapy [15]. The 2006 Ordinance already regulated the practices of anthroposophy applied to health and social thermalism; however, in 2018, they were updated from the document WHO Strategies on Traditional Medicines for 2014-2023 [23].

After the implementation of the PNPIC in 2006, and the inclusion of Complementary Therapies in 2017 and 2018, this policy now includes 29 integrative and complementary health practices. Table 1 list all practices that are part of the PNPIC and the corresponding Ordinances, as a way of facilitating the visualization of what is currently covered by this policy.

	20. Apitherapy
	21. Aromatherapy
	22. Bioenergetics
	23. Family Constellation
Ordinance No. 702, of March 21, 2018 [15]	24. Cromotherapy
	25. Geotherapy
	26. Hypnotherapy
	27. Laying On Of Hands
	28. Ozone Therapy
	29. Flower Therapy

Source: Prepared by the author (2021).

From Table 1, it is possible to see that, although the PNPIC was instituted in 2006, it is in the years 2017 and 2018 that it aggregates most of the practices in its scope.

Before the publication of Ordinance No. 976/2006, the diagnosis made by the Ministry of Health pointed out that only 6.52% of the states and / or municipalities had a law or institutional act on the creation of PICS [4], while in 2018 they were offered in almost 54% of Brazilian municipalities [20]. In addition, according to the third assessment cycle of the PMAQ, in 2016, 31.48% of the teams registered in the Family Health Strategy offered PICS [22]. There was also a greater concentration of services related to PICS in Primary Care: today 78% are offered at this level of care, 18% in medium complexity and 4% in high complexity [20], while before Ordinance No. 976/2006, 42.5% of PICS were offered in Primary Care [4].

Even observing some increase in the offer since the promulgation of the national policy, it is up to the states to submit a proposal for the inclusion of the PICS to the State Health Councils (CES). The objective of this work is to describe specifically the process of construction of the State Policy of Integrative and Complementary Health Practices in Rio Grande do Sul (PEPIC / RS), presented in the item below.

IV. THE STATE POLICY OF INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES IN RIO GRANDE DO SUL, BRAZIL (PEPIC / RS)

In the state of Rio Grande do Sul, the construction of PEPIC / RS is the result of a search for other forms of care, which are more integrative and health-promoting [24]. The state of Rio Grande do Sul stands out

in the production of scientific knowledge in health, with little space for counter-hegemonic practices related to this theme [25]. However, there are recommendations in the resolutions of the state health conferences and a political climate of greater acceptance of these practices. The implementation by the state government of the Intersectoral Policy for Medicinal Plants and Herbal Medicines (PIPMP) opened a space in the political agenda focused on PICS [25].

The PEPIC begins with the creation of a committee for the formulation of a state policy for PICS, in which professionals from the State Health Secretariat (SES) and representatives of the Regional Health Coordinators participated.

Some of these SES professionals already had experiences with PICS and such personal experiences influenced the interest in implementing them in SUS [24]. Thiago and Tesser [26] reveal that the professionals who implement PICS are sensitive to them and understand that they have a broader approach to the health-disease process than other medical rationales, so these professionals look for a personal experience alternative treatment. Thus, the PICS offer depends on the direction that the professional gives to the practice and how he uses this resource. These professionals declare themselves self-taught and many seek knowledge about PICS that they wish to apply outside working hours [27].

Following the appointment of the PEPIC / RS formulation committee in 2012, periodic meetings are scheduled to develop this proposal. The proposal was submitted and approved in December 2013 by the Bipartite Inter-Management Commission (CIB) as Resolution No. 695/2013 [27,17]. The approval of the resolution by this commission enabled it to be approved before the change of state management, guaranteeing the continuity of the

policy [24]. As the State Health Council (CES / RS) is responsible for implementing state policies, in December 2014 it approved the Resolution No. 14/2014 [17]. The fact that the policy was approved by CIB and CES conferred it an important social legitimation and portrays the importance of the political engagement of the actors involved in its construction [24].

For the formulation of PEPIC-RS, the responsible committee recognized the need to carry out a diagnosis that sought to map the municipalities in the state that were already offering PICS within the scope of their public health care network; identify professionals with training in PICS; and to know which PICS, present or not in the PNPIC, were offered by the municipal public health institutions in the state. To this end, questionnaires were sent to 497 municipalities, of which 130 responded. Of this total, 83 municipalities did not offer PICS, in 36 there

were already PICS implemented and in 11 there were trained professionals, but with no offer [16].

The structuring phase of PEPIC took place in 2015 and 2016, when PEPIC / RS was included in the Pluriannual Plan (PPA) 2016-2019 and in the State Health Plan [25]. Soon after, in 2017, with the insertion of more practices in national policy, and greater dissemination of PICS, a phase begins in which doubts about the process of implementing these practices emerge from the growing interest of the population and municipal managers. As a result, the PEPIC / RS management committee was created, which met monthly to discuss and study strategies for implementing them [25]. In addition, working groups were created organized by PICS, which had the objective of regulating a specific practice, preparing Technical Notes made available on the website of the State Health Secretariat and assisting in the implementation of PICS in the municipalities [26].

Table 2: Technical Notes Prepared for State Policy of Integrative and Complementary Practices in Rio Grande do Sul, Brazil (PEPIC / RS)

Technical Note	Guidelines
Technical Note PEPIC-RS / DAS No. 01/2017 [30]	General guidelines for the implementation of Integrative and Complementary Practices. It contains, in addition to the guidelines for the preparation of an Action Plan, guidance on the financing of Integrative and Complementary Practices in the Brazilian public health system and the registration of them in information systems.
Technical Note PEPIC-RS/DAS No. 01/2018 [31]	About Floral Therapy in the Health Care Network.
Technical Note PEPIC-RS/DAS No. 02/2018 [32]	About Yoga in the Health Care Network.
Technical Note PEPIC-RS/DAS No. 03/2018 [33]	About Biodanza in the Health Care Network.
Technical Note - Mental Health /DAS No. 01/2018 [34]	On the insertion of Integrative and Complementary Practices in the activities of Therapeutic Mental Health Workshops in Primary Health Care.
Technical Note PEPIC-RS/DAS No. 01/2019 [35]	Insertion of Chinese traditional body practices in the Health Care Network.
Technical Note PEPIC-RS/DAS No. 02/2019 [36]	Guidelines for the implementation of Homeopathy in the Health Care Network.
Technical Note PEPIC-RS/DAS No. 03/2019 [37]	Insertion of Integrative and Complementary Practices in the Support Groups for Smoking Cessation of the Health Care Network.
Technical Note PEPIC-RS/DAS No. 01/2020 [38]	Guidelines for the implementation of Reiki in the Health Care Network.

Source: Prepared by the author (2021).

From Chart 2, it is possible to see that the team designated by the State Health Department was concerned with structuring PICS implementation manuals so that the municipalities could carry out these actions and start

offering these practices to their users. However, it is important to note that both PNPIC and PEPIC /RS do not create mandatory implementation of PICS, nor do they generate financial benefits. The only existing counterpart

is the PMAQ, which has variables related to the implementation of PICS and, being a quality incentive program in Primary Care, “increases the transfer of funds from the federal incentive to participating municipalities that achieve improvement in the quality standard in attendance” [22].

With this, the Technical Notes created by the team generate an indirect influence for the implementation, as they facilitate this process for the municipalities that intend to do it. However, they do not always encourage the offer of PICS or mobilize managers and professionals who have no predisposition or acceptance of them, since there is no such obligation.

V. THE IMPLEMENTATION OF PNPIC AND PEPIC / RS

PNPIC brought the standardization of PICS, the increase in actions, the qualification of professionals, the development of knowledge related to them, as well as the expansion of therapeutic options to users [7]. Among the possible difficulties for the implementation of the PNPIC, the following stand out: the training and qualification of professionals in sufficient numbers, the supply of inputs, the structure and the investment in the development of technologies [7]. The Ministry of Health points out that, despite the growth in supply and demand for PICS, both in the private and public spheres, there are still some challenges “such as expanding access and supply to these practices, the sustainability of these services through financing involving the three spheres of management, and the evolution in the legislative field that guarantees the right to care and be cared for [20].

In order to mitigate the challenges faced for the implementation of the PNPIC, the Ministry of Health published in 2018 the Manual for the implementation of services of integrative and complementary practices in SUS. This aims to present SUS model managers with a model for implementing the PICS [20].

The Manual presents some strategies adopted by the Ministry of Health to assist and encourage managers to implement PICS [20]. In a very detailed way, it brings suggested steps for the implementation of the practices. Regarding financing, the policy's weak point, constantly cited by authors studying the topic, the suggestion is to include the needs, offers and possibilities of supply of PICS (previously mapped) in the Municipal Health Plan and in the Municipal Budgetary Law [20]. As there is no specific transfer to the PICS to the states and municipalities, it is up to each manager to schedule this financing from the local health plan.

One of the suggestions of the Ministry of Health for the implantation of PICS is the registration of health units and their professionals in the National Registry of Health Establishments (CNES) as well as in the Health Information System for Primary Care [20]. This register enables the planning, monitoring and evaluation of actions related to PICS, as well as contributing to the quality of this information for studies on the theme and other related initiatives. However, as a recent practice, without goals linked to it that generate financial benefits for the municipalities, there is a precariousness in these data.

In order to train professionals interested in offering a service related to PICS, the Ministry of Health suggests that the activities in Permanent Education in Health be used, where there are already courses aimed at this training. Furthermore, it suggests horizontal cooperation between different municipalities and states. In this sense, an important step to facilitate the implementation of PNPIC was the officialization of a Brazilian Network of Integrative and Complementary Health Practices, “an open space for collaboration, articulation, debate, reflection and dissemination to strengthen integrative, complementary and traditional practices in the Unified Health System” [39]. It is formed by social actors, users, managers, workers, researchers and institutions from all over the country [20]. With the objective of “integrating and organizing the different social actors that work, research, teach, study and / or use the integrative practices in SUS to strengthen the practices. Also promote the inclusion of traditional Brazilian medicines” [39]. This reinforces the role of social actors and health professionals engaged with the theme of PICS.

Barbosa et al. [40] analyzed the insertion of PICS based on data from a national survey, collected between 2015-2016, and the PMAQ, between 2013-2014, identifying the absence of consistent data and its low institutionalization in most municipalities. One of the factors that contributes to this is the role of health professionals in offering PICS, linked to personal initiatives and not the health manager [40]. This fact can lead to a punctual diffusion in the Family Health Teams in which there is sensitivity and some competence of the professional in a given PIC, which causes an unsustainability of the policy and restricts it to users of that unit, contrary to the SUS principles of universality of access [40]. Thus, the authors point out the need for managers to take ownership of what is developed in the ESF in terms of PICS and to mobilize institutional resources as a way to implement the PNPIC.

At the state level, in Rio Grande do Sul the role of professionals is also noted [27, 24]. This fact occurs

because even though managers recognize the limitations of the biomedical model, they often reproduce this concept in directing health actions. Thus, despite the manager's incentive, there is no organized strategy for offering these practices. The implementation of PEPIC / RS reinforces the need for the legitimacy of popular knowledge, since the dialogue between them and technical knowledge generates a greater potential to face complex public health problems [24].

Over the ten years of PNPIC implementation, there are difficulties in developing actions and strategies that can operationalize this policy in the different services of the health system. What happens is an informal offer, discontinued and with little perceived appreciation. Although the professionals are distant from the process of articulating the implementation of the policy, it is their initiative to carry out the actions related to the PICS. It is not enough to create a policy for the insertion of PICS to take place in SUS: it is necessary to give visibility and legitimacy to the practices that already happen in health services and to enhance and enable the practices already developed by professionals [27].

In addition, other elements do not contribute to the implementation of the PNPIC, such as professional training, adequate funding and professional availability [40]. Another fact that hinders the implementation of these practices is the absence of specific indicators that are able to respond and adapt to the needs and specificities of practices with a vital dimension [40]. This contributes to the difficulty of comparing the impact of PNPIC and its reflexes to health.

VI. CONCLUSION

It is noticed that despite the PNPIC and PEPIC / RS there are still difficulties in implementing the practices in order to act together with biomedical treatments. This is because the health concept of the SUS medical-care model does not contribute to the effective implementation of PICS. All care logic of the health care network takes the user to a form of curative and medication treatment. So that for PICS to be effective in this system, it is necessary that the logic of SUS itself (in practice) be able to embrace this other meaning of health / medical rationality and to integrate these forms of care.

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