

## Professional Training in Integrative and Complementary Practices: the meanings attributed by Primary Health Care workers

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**Abstract** *Objective: To understand the meanings attributed by Primary Health Care workers to the professional training process in Integrative and Complementary Practices. Method: Descriptive, exploratory study with a qualitative approach, carried out with 20 professionals from 14 health units in three municipalities in the Metropolitan Region of Goiânia, state of Goiás, Brazil. Data were collected through semi-structured interviews, transcribed and analyzed using the thematic content analysis. Results: Based on the analysis, the thematic category about training trajectories in Integrative and Complementary Practices emerged. It discusses that the training takes place through training provided by federal and municipal management or professional councils, via distance, semi-presential learning or in-person training. Furthermore, training courses are held at private educational institutions funded by the professionals themselves. Additionally, informal sources of information are used to obtain knowledge (internet, books and magazines). Conclusion: The results show, on the one hand, insufficient and diffuse training, with limited supply and quality and, on the other hand, the need to increase educational strategies to improve the training of health professionals aiming at providing different Integrative and Complementary Practices in the Primary Health Care.*

**Key words** *Complementary therapies, In-Service training, Continuing education, Primary Health Care*

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## Introduction

With the advent of the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*), the education of health workers has become more relevant. The Brazilian Federal Constitution, in its article 200, establishes that “the Unified Health System is responsible, in addition to other attributions, under the terms of the Law, for requiring the training of human resources in the Health area”<sup>1</sup>. For this reason, the training of professionals is the responsibility of the Ministry of Health. Law number 8080, of September 19, 1990, known as ‘Organic Health Law’, reinforces, in its Article 27, that it is the responsibility of SUS “the implementation of a human resources training system at all levels of education, including postgraduate courses, in addition to the development of programs for the permanent improvement of personnel”<sup>2</sup>. The abovementioned notes about the federal laws show the consensus that, for the consolidation of SUS, it is necessary to create the health teaching content, with clear definitions and that promote the awareness of workers regarding the implementation of the principles of universality, equity and social participation<sup>3</sup>.

Professional training is also present in the National Policy on Integrative and Complementary Practices (PNPIC, *Política Nacional de Práticas Integrativas e Complementares*), which has as guideline the “development of qualification strategies in Integrative and Complementary Practices for SUS professionals”<sup>4</sup>, to ensure the its implementation is carried out in a safe and effective way, taking into account the paradigms that underlie them, with a view to care in the construction of integrative health care to the population<sup>5</sup>.

However, university education in health has a strong tendency to undervalue integrative health care, as it teaches professionals to reduce the individual by focusing on the disease or the risks inherent to the latter. On the other hand, integrality is presented as a key element for the organization and foundation of Integrative and Complementary Practices (PIC, *Práticas Integrativas e Complementares*), as an ethical and epistemological principle. Thus, the teaching of an alternative and complementary medical rationality suggests that students are able to integrate other worldviews into their own understanding of knowledge and science. As a result, future SUS workers would be less dualistic and reductionist professionals from the moral point of view, contributing to improve the relationship with us-

ers, reducing the use of invasive treatments, and making health work more resolute<sup>6-9</sup>.

However, training in PICs can be little attractive, considering an increasing sectorization of the health field. The requirements for a professional trained in a rationality other than biomedicine may be less attractive to meet the managerial expectations imposed to guarantee the “good” functioning of health services<sup>10</sup>. From this perspective, overcoming the negativity of the relationship between work and professional education in an attempt to revert the traditional biomedical, elitist, commoditized, corporatist model and focused mainly on the care of diseases in health care services is not an easy task<sup>11</sup>. Under this unfavorable circumstance, we still do not know how health professionals have been trained in PICs to offer them in Primary Health Care (PHC).

At the international level, 46% of Swiss doctors, including those from PHC, have some training in PIC. The contents encompassing PIC are present in over 80% of medical schools in Canada, with Acupuncture and Homeopathy being the most widespread ones. Moreover, they are taught in 40% of medical courses in the European Union and in 64% of medical schools in the United States<sup>12-13</sup>.

In contrast, in Brazil, PIC training is considered one of the most critical points for its expansion<sup>6,14-18</sup>. In the health area, only 26% of nursing schools at public universities offer subjects related to PIC<sup>19</sup>. In Medicine, of the 272 Brazilian medical schools, only 57 have addressed PIC in their curricula in the last ten years. Therefore, there has been no significant increase in PIC teaching, even considering the needs of SUS<sup>20</sup>. Therefore, we realize that most of the studies involving PIC training have focused on the analysis of university curricula. An intriguing and still little explored area in the field of PIC training comprise the perceptions of the people involved in the training process<sup>21</sup>. Therefore, our concern starts here: how does the training in PICs take place from the perspective of the health professionals who offer them in PHC?

If the curricular structures of health courses inflict limits on PIC training<sup>17</sup>, justified by the extremely biomedical culture, professional corporatism and also for following a logic based on isolated and fragmented contents, with a focus on individual care<sup>22</sup>, then we consider that the training processes of health professionals can mostly be carried out in postgraduate studies and in private education. This is the sense presented by

this study, which aims to understand the meanings attributed by Primary Health Care workers to the professional training process in Integrative and Complementary Practices.

## Methodology

This is a descriptive and exploratory study, with a qualitative approach. It integrates the research project entitled: “Integrative and Complementary Practices in Primary Health Care Services – Metropolitan Region of Goiânia”, which corresponds to the research proposal carried out in the Metropolitan Region of Campinas by the team of the Laboratory of Complementary and Integrative Practices (LAPACIS, Laboratório de Práticas Complementares e Integrativas) <http://www.fcm.unicamp.br/fcm/lapacis> of Universidade Estadual de Campinas. It constitutes the extended version of the text published in the Minutes of the Ibero-American Congress of Qualitative Research (CIAIQ), held in Lisbon, Portugal, in 2019.

Initially, to identify the PICs and the professionals who offered them, the PHC services of the Metropolitan Region of Goiânia (RMG) were checked in the National Registry of Health Establishments (CNES, Cadastro Nacional de Estabelecimentos de Saúde) system. A total of 274 PHC services were identified, comprising community health centers and Family Health Strategy centers, Extended Family Health Centers (NASE, Núcleos Ampliados de Saúde da Família) and Health Academies. For this study, a letter of consent was obtained from 17 municipalities among the 20 that constitute the RMG, totaling 234 PHC services.

A telephone contact was made with the managers of the health units to check the CNES registration, and 53 of the 234 services were excluded, considering the criteria: building renovation, refusal to participate in the interview, the local manager’s schedule and telephone line problems. Regarding the second semester of 2017, there were 23 PHC services, in which 29 some professionals offered some type of PIC, in five municipalities located in the RMG.

Of the 29 identified professionals, seven did not participate in the study: one refused to participate; three were not contacted and three had discontinued the PIC offer. The exclusion criterion included those health professionals who, due to absence, vacation or leave of any kind, were not at the PHC services at the RMG during the data collection period, which included the

months of January to August 2018. Therefore, two professionals were excluded, as both were on a three-month sabbatical. Ultimately, the study included 20 professionals, from 14 PHC services, from three municipalities of the RMG.

The interviews were previously scheduled with the professional through telephone contact. At this first approach, the researcher and the research, its objectives and relevance were disclosed. Subsequently, the invitation was made to participate in the study, and the interview was scheduled to take place on a day and time according to the availability of each of the interviewees.

The interviews were carried out guided by a previously prepared script that allowed basic questions to be asked, as well as addressing issues relevant to the investigation, such as: “Tell me a little about your professional training (College, vocational course, specialization, etc.); “What did you do to train yourself in the PIC area (courses, specialization, seminars, etc.)?”

At the time of the in-person and individualized interview, a brief contextualization and clarification of any questions about the research were carried out. Then, the Free and Informed Consent form was handed to the interviewees to be signed by them, safeguarding their identity and the confidentiality of the provided information. After that, the interview was conducted with the participants, lasting, on average, 45 minutes, in a private environment and considered the most convenient for the professional (at the place/ area where the PIC takes place or PHC service consultation office), as the interviewee needs to feel comfortable at the place where the interview is taking place<sup>23</sup>. The interviews were recorded on audio and transcribed in full.

The content analysis was carried out using the thematic modality, guided by the method proposed by Bardin<sup>24</sup>, which consists in a set of techniques to analyze the discourses aiming to obtain, through systematic and objective procedures, the inference about what was discussed in the messages. The data organization was divided into three stages: 1) pre-analysis; 2) assessment of the material and 3) interpretation of the results. The pre-analysis consisted of a fluctuating reading of the material, to identify the meanings attributed by the participants. For the assessment of the material, detailed readings of the identified meanings were made, aiming to group the convergent / divergent ideas that appeared with greater relevance.

Based on this stage, the following cores of meaning emerged: training offered by the Min-

istry of Health and / or Municipal Health Secretariat; training in the private sector; offer of PIC without formal education; lack of training in PIC offered by the public sector; limited course workloads; lack of management support for PIC implementation after the training; training in PICs related to integrality. For the interpretation of the results, the analysis category “PIC formation trajectories”, related to the cores of meaning was discussed. For data organization and systematization, a research support program with non-numerical and unstructured data was used<sup>25</sup>. The discourses were coded with the letter “P”, plus the number assigned to each research participant. The project was approved by the Research Ethics Committee under Opinion N. 2,057,783.

## Results

Twenty SUS workers from different professional backgrounds participated in the study, comprising six nurses, two psychologists, two physiotherapists, two social workers, two nutritionists, two pharmacists, a nursing technician, a community health agent, a dentist/dental surgeon and an occupational therapist. The most frequent PIC was Auriculotherapy, offered by nine professionals, followed, respectively, by Reiki, Community Therapy, Phytotherapy, Art Therapy, Shantala and Acupuncture.

Of the interviewees, 18 had finished College/University, 14 of which had a Lato Sensu post-graduate training, whereas two had a Stricto Sensu Master’s degree. Among these health workers, 15 were females, professionally experienced, of which a significant majority (12) had more than ten years since graduation. Of the total, seven workers were in the age group between 31 and 40 years old and 14 had a permanent (stable) employment bond. Among these professionals, eight self-declared as white, 10 were married and seven self-declared as Catholic.

Overall, the trajectories that led these professionals to seek training in PICs were distinct and convergent at the same time. This finding can be demonstrated in the disclosure of the core meanings that emerged from the professionals’ narratives, explaining how these health professionals sought to obtain training in a new therapeutic practice and the meanings attributed by them to the PIC training.

It was observed that this training takes place through a short-term course, in-person or at distance, offered by the Ministry of Health, Muni-

pal Health Secretariats and professional councils, in which nursing professionals stand out. There were also those who were trained in private institutions, supported by the workers’ own financial resources. It was also observed that the offer in PHC is implemented by professionals who do not have the formal training in PICs.

Professionals who offer Auriculotherapy go through different programs to learn this therapeutic practice, which is part of the Traditional Chinese Medicine. One of the training courses taken by two professionals, a pharmacist and a nutritionist, consists of:

*a course provided right there by the Ministry of Health. An online course, with five or six modules. There was no tutor or anything. We entered the site, there was the material for you to print, also some videos. This course was offered in partnership with Universidade de Santa Catarina (P2).*

*... for the last module, you had to go in person to a class and then each person who registered chose in which city they wanted to take this practical class. I took this practical class in a part-time period. They did not focus too much on teaching the theoretical part, no. They really taught the practical part (P7).*

Another type of training in Auriculotherapy was carried out through a course provided by the Municipal Health Secretariat of the municipality of Goiânia, state of Goiás, Brazil. The pharmacist who took this training explains that:

*...we attended the Auriculotherapy course on Fridays, it was held at the beginning of January, it consisted of four Fridays. [It was carried out in] one period, the afternoon period. The treatment of 24 users is part of the course, and we have to report the treatments and also send the reports to our tutor, so we can complete the course workload, of about 40 hours (P9).*

In addition to the Municipal Health Secretariat of Goiânia and the Ministry of Health, the Regional Nursing Council also provided training in Auriculotherapy. The course, according to the participating nurse,

*...it lasted three nights, from six to ten PM, a 12-hour workload. And in this course, she [the instructor] started with the theoretical part, talked about its origin, explained everything. It comprised two days of theory and one day of practice. At the practical training, she showed us, defined exactly how it works, what auriculotherapy is, that is a Chinese therapeutic medicine, explained to us how it works, its purpose and we practiced among ourselves (P14).*

Other three professionals received training in Auriculotherapy in private institutions. Two of

them, in a module carried out in their specialization in Acupuncture. The third one paid for her own training, in a course aimed at the use of Auriculotherapy, with a 20-hour workload, in person, during one weekend.

Regarding Phytotherapy, the Hospital de Medicina Alternativa de Goiânia, in 2016, provided a training course taught by the two professionals who use it in PHC at the RMG. There was no connection with the municipal, state and federal administrations. It comprised a weekly meeting in the morning, during six months, being carried out during the working hours.

The professionals who offer Reiki in PHC at the RMG explain that:

*We took the course on our own, we paid for it [...] for Reiki, it has several levels, I only took one level, and then how long did it last? The course takes about 20 hours (P3).*

*It was not paid by the Secretariat, it was a private one. The course lasted 40 hours (P17).*

*It was on our own. The [Reiki] course took place on the weekends. It lasts 20 hours (P18).*

The training of nurses that includes Acupuncture also took place in private schools. The professionals told us that the courses are Lato Sensu specializations, lasting one year and eight months to two years:

*The course [acupuncture] lasts 24 months. I am in the fifth module. It is in-person, on weekends. This course was not offered by the Health Secretariat. I was the one who sought this course (P11).*

*The course is private, I paid for it myself. The course is in-person, we have classes once a month and after six months of course we do [the practice] at the clinic. The outpatient clinic is a space where you treat the patients, so people go there and you treat them, you practice what you have learned (P12).*

*[The course] was my own (initiative). I looked for it. It lasted one year and eight months, a year and a half with theoretical and practical classes and three months of practice only (P16).*

Another specialization training was the Community Therapy, which was made possible for the interviewee only through the partnership between the Pastoral da Criança e do Adolescente in collaboration with Universidade Federal do Ceará, in Brasília. The professional points out that the course usually took intensive Fridays, Saturdays and Sundays. The course took 360 hours. It was divided between in-person meetings and internships. During the course, part of the workload consisted in the use of techniques in our workplaces (P10).

The other Community Therapy professionals, together with the workers who offer Art Therapy and Shantala, constitute the group that has no formal education in the PIC. Therefore, they sought other sources for knowledge acquisition:

*I bought the book, started to study. So, that was the way I graduated, so to speak (P5).*

*Ever since I can remember, I used to see my mother doing it and I learned from her (P6).*

*It was like that, we bought magazines, we learned from magazines (P15).*

*Not from academia, no. We did it by getting up the courage and watching videos (P16).*

On the other hand, for professionals with more technical academic backgrounds, such as dentists, the Auriculotherapy course awoke them to a more comprehensive care, which produces a lot of deconstruction of that care that comprises medication only, centered on the biological aspect. There is a deconstruction, so that we can understand the whole (P11).

It was observed that the professionals who offer the PIC have finished their academic training a considerable time ago and have experience in PHC at the RMG. However, for an interviewee, who graduated more than 10 years ago, there is a lack of alternatives for training in PIC:

*I did not have the possibility, the privilege of doing it through the Secretariat without having to pay for it. I think it should be (free), we should have it in SUS (P8).*

Considering this, the lack of educational strategies makes the professionals afraid to carry out the practice. This feeling is shared by the workers, especially those who do not have a formal education in PIC. One of the community therapists says that it is not something that you feel safe with, totally safe. Because I think you need this training. Yes, it is necessary (P13).

Participants report limitations on the training offered by the Ministry of Health and/or Municipal Health Secretariat. They consider the reduced workload one of the main negative points in the training and / or professional qualification:

*The workload consisted of 20 hours, in-person, at a school right here in Goiânia. I find twenty hours too little time to understand Traditional Chinese Medicine (P11).*

*I think it was not enough. It was too fast. The course lasted for three months, only once a week. The classes were more theoretical than practical. And so, I think it was really not enough (P1).*

One of the workers, reports Do you believe that after signing the document to take the course, they wanted to cancel it? It never offers any courses, and

when it does, it looks like this: *Where's the authorization? Has the Secretary authorized it? It was not to be authorized. I think it is due to the absence [from work] (P1).* This lack of incentive to take courses, supervisions and refresher courses was observed in the interviewees' discourses, and this difficulty is even greater for those workers who have an unstable employment bond.

In addition, the provision of training has not been accompanied by the financial resources for their implementation in health services, *It is the coordinator herself, who is promoting this Auriculotherapy course that is taking place, she was going to talk to the people. To tell the people [professionals] to invest in the plates [of needles for Auriculotherapy application], only (P4).* The support and regulation of practices have not been identified in practice, *In theory, the central management supports it, so much so that they provided the course and everything. Now, the actual practical support, the question of materials, etc., that has not happened yet (P9).*

## Discussion

Although the Brazilian Ministry of Health has responded to the call of the World Health Organization<sup>4</sup> and several professional categories in the health field in Brazil with the creation of the PNPIC, the establishment and implementation of PIC in SUS must be increased, especially in relation to the training of professionals who offer them in PHC. The cores of meaning that emerged from the narratives of the professionals participating in this study are transversely intersected by the analysis category related to the trajectory of PIC training.

In this study, we show that some professionals turn to the private sector for PIC training. This corroborates previous findings in the literature<sup>10,14,21,26,27</sup>. PIC training in the country has been concentrated in the private sector, through Lato Sensu postgraduate courses<sup>10,14,28</sup>. This type of training can be a problem, since it tends to replicate educational models focused on the reality of private practice, which do not meet the context of PIC in PHC and SUS<sup>16,28</sup>.

On the other hand, we found that the training and qualification processes of professionals who were offering PIC at the RMG occurs through a course offered by the Municipal Health Secretariat of Goiânia. This type of training is observed in other realities in the country<sup>29,30</sup>. This type of training, even though timid and introductory,

can play an important role in the face of significant lack of knowledge and the interest of professionals working in PHC in relation to PIC<sup>16</sup>.

In this follow-up, the Ministry of Health has also contributed, although in a discreet way, to the training of our interviewees. This 80-hour semi-presential Auriculotherapy course trained more than 4,000 professionals in the period between 2016 and 2017<sup>31</sup>. This initiative by the federal government has not yet been extensively explored, and studies in area must be performed<sup>16</sup>. The results of these future studies may indicate that this type of training allows the expansion of PIC in PHC.

Our study also found that other sources of knowledge were used to obtain information (internet, contact with other people, books, magazines). This fact can become a matter of concern when we observe, through the reports, that the information comes from electronic means and personal research, disclosing an informal character for an important area for human health. These mechanisms can compensate for the lack of academic resources that train professionals to work with the demands of health services, despite the initiatives that have been taken in recent years<sup>32-34</sup>.

Our findings point out that PIC training and qualification favors a more comprehensive view of work in the health area. This evidence is consistent with the result of another study<sup>35</sup>. The integrality, recognized as an objective image among the constitutional principles of SUS, has stood out for indicating the return of subjective and social dimensions as constituting the health know-how<sup>36</sup>. Therefore, education in PIC improves the interviewees' professional practice, making them more empathetic with and more interested in the users.

Our interviewees report the lack of educational options in PIC in SUS, having to bear the costs of their own training. Furthermore, this lack leaves the professional feeling insecure regarding the offer of PIC at work. These results further strengthen the concept that currently, the training of health professionals has not kept up with the offer of PICs in health units, which can increase the fragility of their care<sup>37-40</sup>.

Our data show that PIC training is poorly presented, which can limit these professionals' understanding. This finding corroborates the results of another study<sup>41</sup>. The professionals consider the training and its practice complex, criticizing the short-duration courses. This complexity requires such an understanding that, in a

short period, it can result in deficient training for the performance of good practice.

The several coexisting medical rationales come from different cultures, with different concepts of health and illness. Hence, offering training in PICs in a simplistic way may still cause the risk of submitting one paradigm to another, with losses in their contributions<sup>27</sup>. Therefore, we consider that the training of health workers must have a better basis to intensify the points of approximation and intersection of biomedicine with PIC, conveying the possibilities of interaction, complementarity and collaboration in the training of more sensitive professionals with increased and comprehensive health care<sup>42,43</sup>.

Thus, to ensure that professionals are adjusted to the logic of integrality, an investment is required, in addition to their basic degrees, and it is essential to increase collaborative skills to overcome individual and hierarchical work within the services. These changes are difficult to face, as the professionals were trained in biomedicine that privileges individual and specialized work. Being trained in another reasoning that differs from the “normality”, configures a new logic in the action of these professionals, which at the same time produces constraints due to the motivation to escape the immobility that the health system has imposed on its workers<sup>44</sup>.

Moreover, our study found that being absent from work generates conflicts between the professional and the management, making it an element of discord for the training in the PIC. The organization of health care has alienated the worker, and a process of reification of its essence has occurred, that is, a strangeness of its own human condition, with consequences for its social relations. Learning PIC in this unfavorable environment can become daring and bring moments of fissure in the established processes<sup>3</sup>.

This becomes more evident when the professionals report that, even with the offer of training, there is no supply of materials for the implementation of the practice. This difficulty faced by the alternative public health worker is easily found in the literature<sup>45-47</sup>. Alone, PIC training, whether virtual, in-person or semi-presential, does not guarantee its implementation. The training must be accompanied by favorable conditions for the development of practice. Thus, we demonstrate that the performance of the PICs is developed without manager support and without significant institutionalization of the offer<sup>16</sup>.

Consequently, our methods should include the health service managers' meanings about PIC

training, since they are also important actors in health training, indicating one of the limitations of this study. Another limitation comprises the period of data collection, which could be more comprehensive, as the PIC training was being offered at that time at the RMG.

## Conclusion

Our study led us to the conclusion that the professionals' PIC training process aiming at offering them in PHC occurs through training provided by the federal, municipal or professional councils. We also found that health workers finance their own training in private education, as they do not find training in certain PICs in the public sector. In this study, we also observed that obtaining knowledge about the PICs can occur informally, using media sources, which reinforces the lack of creation of PIC educational initiatives for the training of professionals in SUS. Therefore, our data demonstrate that training has not been restricted to private institutions, as we had initially considered.

Together, these results suggest that the PIC training processes are heterogeneous, deficient and limited. The findings of this study indicate the lack of demand for human resources training and development of qualification strategies in PIC. Overall, these results show a relative technical and political unpreparedness of health professionals to implement PICs in PHC. However, even with introductory training, our findings show its capacity to stimulate changes in the biologizing and medicalizing pattern of health care.

Our results indicate the need to expand educational strategies that cover the totality of therapeutic practices contemplated in PNPIC. In this sense, this study has somewhat shown some advance regarding the improvement of our understanding of health professionals' training in PICs, as it suggests some actions to be observed when training is offered at SUS, such as: training with a longer workload; encouragement and support from health service management for the training; and availability of materials for the practice implementation.

Consequently, we hope to encourage the discussion in academic and management circles regarding the importance of PIC training for their inclusion in PHC. Having health professionals that able to perform these practices is a way to recognize their worth and make them more available to the entire population, bringing im-

provements to users and workers of the Brazilian Unified Health System.

### **Collaborations**

PHB Silva, LCN Barros, NF Barros, RAG Teixeira and ESF Oliveira contributed substantially to the design and planning of the study; in obtaining, analyzing and interpreting data and in writing and critical review and approved the final version to be published.



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Article submitted 07/04/2020

Approved 26/05/2020

Final version submitted 28/05/2020

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