

# Integrative and Complementary Practices in the Unique Health System: implementation, advances and challenges

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## ABSTRACT

This study aims to present an essay analyzing the implementation process, advances, and challenges of the National Policy on Integrative and Complementary Practices in the Unified Health System. Data collection was conducted through the review of scientific articles, dissertations, theses, and official publications of the Ministry of Health, in the years 2006 to 2023. The National Policy of Integrative and Complementary Practices in the Unified Health System was made official in 2006 to include Integrative and Complementary Practices in the Unified Health System. Today they total 29 and can be offered individually, in groups, and both ways. The growth and expansion of these practices in the unified health system is notorious, especially in Primary Health Care. It presents itself as advances: growth in the number of health establishments that offer them, inclusion of the theme in the Portfolio of Primary Health Care Services, development and qualification of professionals, expansion of its dissemination and exchange of experiences between countries. Challenges include funding, professional training, incentives for research, monitoring, and evaluation. They present an approach to the health-disease process and comprehensive care, being a potential for the implementation of the care model in Primary Health Care services. Much progress has been made in the implementation of integrative and complementary practices, but measures are needed to encourage their expansion. It is also necessary to have financial incentives to guarantee strategic inputs, and training in complementary integrative practice for health professionals and managers, so that they can be sensitized on the subject. It should also be noted that the monitoring and evaluation of Complementary Integrative Practices depend, most of the time, on information system records that, due to the lack of definition of the scope of the National Policy on Complementary Integrative Practices, may be inadequate. There are gaps in evaluations regarding these practices in Primary Health Care. Future studies are needed to analyze the implementation of Complementary Integrative Practices in different regions since this measure can contribute to the continuous improvement and organization within the scope of the Brazilian health system.

**Keywords:** Unified health system, Primary health care, Complementary therapies, Humanized assistance, Integrality in health.

## INTRODUCTION

In recent decades, the use of Integrative and Complementary Practices (ICPs) has increased worldwide<sup>1</sup>. Since the Alma Ata Conference, the World Health Organization (WHO) has encouraged their

use among member countries as an alternative form of care that is not present in biomedicine; it is one of the perspectives for changing the paradigm used in health care<sup>2</sup>.

ICPs are characterized as a set of therapeutic practices and actions that advocate comprehensive patient care,

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considering the body, mind, and soul. They include therapeutic methods that involve approaches that stimulate the natural mechanisms of disease prevention and health recovery through effective and safe technologies, with an emphasis on welcoming listening, the development of a therapeutic bond, and the integration of the human being with the environment and society<sup>3</sup>.

In Brazil's Unified Health System (UHS), the National Policy for Integrative and Complementary Practices (NPICP) was instituted in 2006 to complement medical treatments and provide users with new therapeutic care<sup>4</sup>. ICPs can be offered in the UHS at all points of health care, but the NPICP encourages them to be implemented primarily in Primary Health Care (PHC), as it is the user's first contact and preferred gateway to the Health Care Network (HCN)<sup>3</sup>. By including ICP in PHC, it is understood that the NPICP contributes to the implementation and strengthening of the UHS insofar as it favors fundamental principles such as "universality, accessibility, linkage, continuity of care, comprehensive care, accountability, humanization, equity, and social participation"<sup>3:23</sup>.

The provision of ICPs to the population was interrupted during the COVID-19 pandemic and had an impact on the mental health of workers, influencing the search for care strategies that included ICPs<sup>5</sup>.

Considering that the inclusion of NPICP in the UHS aims to provide new preventive and therapeutic options for users, especially after the pandemic, as well as expand the work of health professionals<sup>4</sup>, the motivation for this study emerges, whose objective is to present an essay analyzing the implementation process, advances and challenges of NPICP in the UHS.

## METHODS

This is a descriptive cross-sectional

study, which is widely used to support public policies by recognizing vulnerable groups, the prevalence of risk exposures, and/or risk surveillance<sup>6</sup>.

Articles on the NPICP were retrieved from the Virtual Health Library (VHL), dissertations and theses from the Coordination for the Improvement of Higher Education Personnel (Capes) catalog, and official publications such as legislation and manuals from the Ministry of Health (MoH) website. The review was carried out from 2006, when the NPICP was implemented, to 2022, using the descriptors Integrative and Complementary Practices, Unified Health System; Complementary Therapies; and Complementary and Integrative Medicine in the search.

## RESULTS AND DISCUSSION

### Implementation of ICP in the UHS

The implementation of ICPs in the UHS began with the WHO in the mid-1970s with the advent of the Traditional Medicine Program. The implementation of traditional medicine was recommended by the Declaration of Alma Ata in 1978 and is characterized by the sum of knowledge, skills, and practices based on theories, beliefs, and experiences of different cultures, explainable by current scientific methods or not, used to maintain health and prevent, diagnose, improve or treat physical and mental illnesses<sup>4</sup>.

Next, it is important to highlight the 8th National Health Conference, which took place in 1986 and is considered a benchmark for the provision of ICPs in Brazil, with its final report calling for the "introduction of alternative health care practices within the scope of health services, allowing users democratic access to choose their preferred therapy"<sup>4:11</sup>.

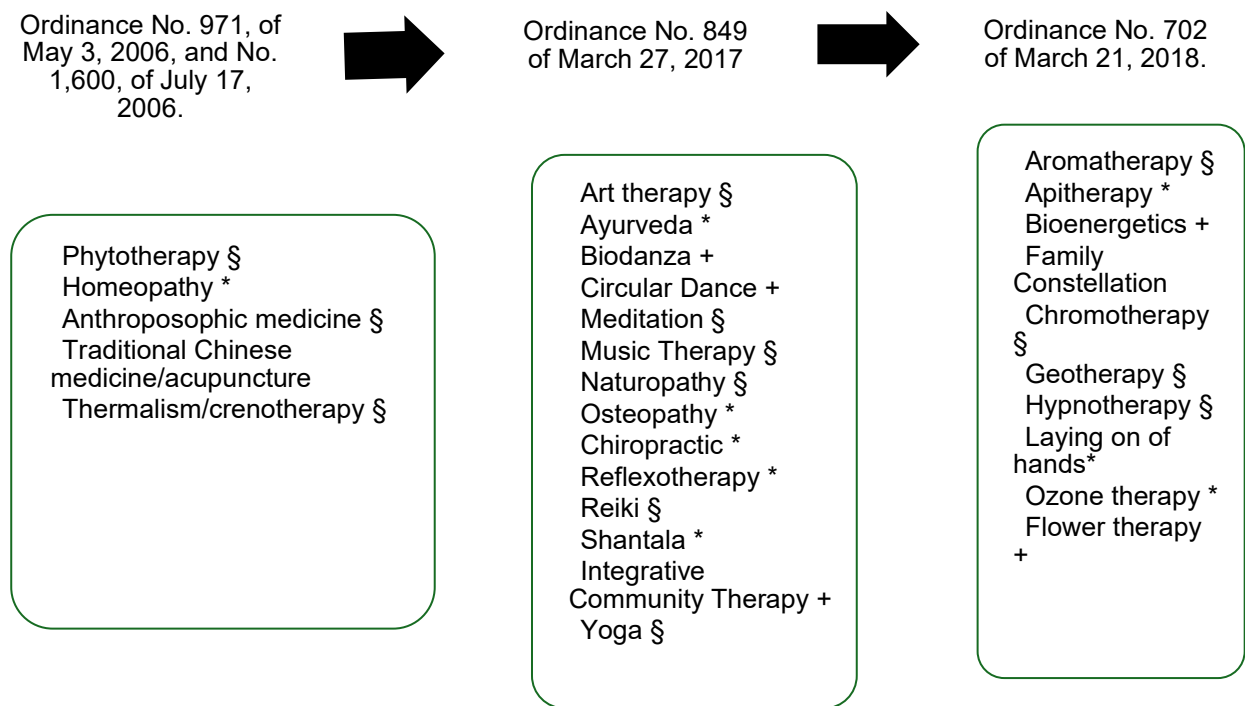
The drafting of the National Policy for Natural Medicine and Complementary Practices in the UHS, the current NPICP, began in 2003 and was made official in 2006

with the publication of ordinances<sup>4,7</sup>. This policy aims to expand the supply of ICPs in the UHS with quality, effectiveness, efficiency, and safety, with an emphasis on the prevention of illnesses, health promotion, and recovery, considering continuous, humanized, and comprehensive care<sup>3</sup>.

Initially, the NPICP listed five practices (Figure 1)<sup>4</sup>, and these choices

were justified by the fact that their practitioners were more representative to legitimize, through this policy, those that were already used in the health care of the population. In 2017 and 2018, new therapeutic resources were included, expanding the procedures offered by the UHS<sup>8,9</sup> (Figure 1). As a result, the UHS now offers 29 PICs approved in the national policy<sup>4,8,9</sup>.

**Figure 1:** Timeline of the inclusion of Integrative and Complementary Practices in the Unified Health System.



\*Individual ICP † Collective ICP § Individual and collective ICP

Source: Ordinance No. 971, of March 3, 2006; Ordinance No. 1,600, of July 17, 2006; Ordinance No. 849 of March 27, 2017; Ordinance No. 702 of March 21, 2018. Data collected by the authors.

The implementation of the NPICP had a political, technical, economic, social, and cultural character, making it possible to spread these practices in various regions of the country<sup>4</sup>. Two years after its creation, 30% of Brazilian municipalities drew up their own legislation for the use of these therapies, which meant a significant increase in the expansion of the policy<sup>10</sup>.

They are currently offered in 77% of cities - in the capitals, the percentage is 100%<sup>11</sup>.

The most commonly performed practices in PHC between 2017 and 2019 were auriculotherapy, followed by needle insertion acupuncture, electrostimulation sessions, acupuncture with the application of suction cups/moxa, massage therapy, and reiki. Auriculotherapy was the fastest-

growing procedure: it rose from 40,818 to 423,774 in this period<sup>11</sup>.

PICs have been increasingly sought after due to the preference for the way professionals welcome and treat users, including a holistic approach, taking into account psychological and social aspects and a better way of understanding illness and suffering. Added to this is the fact that these practices have a low technological density, providing satisfactory results and lower risks of side effects when compared to conventional treatments<sup>12,13</sup>.

ICPs can be developed individually or in groups, as described in Figure 1. Groups

have a more dialogical perspective, with people co-participating and being autonomous, and are a space for exchanging experiences, mutual help, and social support<sup>14</sup>. Collective activities experienced a 314% increase in 2019 compared to 2017<sup>11</sup>.

Data from the Ministry of Health for 2019 shows that 90% of ICPs are inserted in PHC, and 10% in medium and high complexity<sup>11</sup>. A study carried out in five large Brazilian municipalities identified four scenarios for the inclusion of ICPs in the UHS<sup>15</sup>, as described in Figure 2.

**Figure 2:** Scenarios for integrating Complementary Integrative Practices into the Unified Health System.

1	2	3	4
PHC professionals carry out ICPs alongside their other healthcare duties	Professionals other than the minimum PHC team dedicate themselves exclusively to PICs	ICPs are carried out by professionals from the Expanded Family Health and Primary Care Center	Implementation of ICPs in specialized outpatient clinics* (biomedical or ICP-only) and hospitals†

*\*Medium complexity services. † High complexity services.*

Source: Souza; Tesser (2017).

As the PHC service is the user's preferred gateway to the UHS, this level of care is the place with the greatest potential for implementing ICP<sup>16</sup>, and it is up to the manager to decide between scenarios 1, 2, or 3.

In this sense, the Family Health Strategy (FHS) is seen as the driving force behind the reorientation of the PHC model, as it offers continuous care to a population in a defined territory, with a commitment to providing comprehensive care for the health of families through interdisciplinary work in a multi-professional team<sup>17</sup>. Thus, all health

professionals should be encouraged to expand their knowledge of health and their practices beyond the biomedical model, realizing that individuals should be considered and treated in their entirety<sup>18</sup> and providing them with new preventive and therapeutic options through ICPs.

ICPs can be developed by various healthcare professionals. A study that used the UHS Information Technology Department (Datusus) database from 2010 to 2018 as a source of evidence identified multiprofessionality in the ICPs carried out in PHC. Physiotherapists, other health team

professionals and non-medical professionals (chiropractors, holistic therapists, health caregivers, nursery attendants, physio-corporal counselors), Community Health Agents (CHAs), Community Endemic Diseases Agents (CEAs), physical education professionals, physicians, occupational therapists, social workers, psychologists, and nutritionists were the ones who provided the most care in PICs<sup>19</sup>.

It is worth highlighting the significant role of CHAs and CEAs in ICP procedures<sup>19</sup>. A study carried out in a northeastern municipality showed that, in PHC services, CHAs are the professionals who carry out the most group ICPs<sup>20</sup>. The use of these practices by CHAs, stimulating health promotion and recovery, is a positive factor for them to recommend them to families in their territory, helping to strengthen the NPICP. It is also necessary to train them so that they can inform the population about ICP<sup>20</sup>. In this context, CHAs have great potential, as they are members of the health team and the community<sup>14</sup>.

To expand the health services available, ICPs were included in the scope of actions of the Expanded Family Health Center (EFHC) in 2008 and later in the Primary Care EFHC (EFHC-AB) in 2017, with the inclusion of homeopathic doctors and acupuncturists, as well as other professionals practicing ICPs<sup>21,22</sup>.

Given the above, the implementation of the NPICP has the potential to strengthen the UHS, as it favors the empowerment of professionals, promotes autonomy and awareness among users and families, as well as creating new possibilities for care<sup>23</sup>, especially in the field of health promotion and disease prevention.

## Progress

Brazil stands out in the implementation of the NPICP through the NPICP, which is part of a universal public health system and integrated with the entire

network of health services, with the priority of insertion in PHC, without devaluing the offer in the medium and high complexities<sup>10</sup>. In 2008, two years after this policy was approved, the Department of Primary Care (DPC) of the Ministry of Health carried out a situational diagnosis of ICPs in the UHS to identify their scope and stage of implementation<sup>10</sup>. It emerged that 72% of PICs were included in PHC, especially in FHS teams. Concerning the practices offered, of the 4,051 municipalities that responded to the survey, 7% offered homeopathy, 4.5% traditional Chinese medicine/acupuncture, 9% herbal medicine, 1.5% spa/crenotherapy, and 1% anthroposophic medicine<sup>10</sup>.

According to data from the Ministry of Health, in 2019, ICPs were offered in 17,335 HCN services in 4,297 municipalities (77%) and all Brazilian capitals. There was an increase of 16% (2,860) in the number of services compared to 2017<sup>11</sup>. According to the level of care, 15,603 (90%) of ICPs are in PHC, which represents an increase of 16% (2,480)<sup>11</sup>. This scenario shows that there has been an increase in ICPs in the UHS concerning the number of health establishments and services, as well as their appreciation of the health-disease-care process<sup>22</sup>.

With regard to the structure and strengthening of ICP care in the UHS, it is worth noting that, in 2013, a public call for proposals was published for municipalities, states, and nations, making resources available for the acquisition of supplies for services; actions to disseminate and/or raise awareness among health workers, managers, and social control; and processes of permanent education in ICP, including the development of teaching materials. The significant number of proposals received represents the interest of several municipalities in implementing and/or strengthening the NPICP<sup>22</sup>.

Currently, the Primary Health Care Services Portfolio (CaSAPS) - a document instituted by the Ministry of Health in 2019, which aims to guide health actions in PHC - includes the provision of ICP in comprehensive health care for children, adolescents, adults, and the elderly. However, it is up to each municipal manager to add, remove, or reformulate items in the CaSAPS according to local needs and conditions and to adapt the provision of services to their own reality<sup>23</sup>.

One of the local conditions for offering ICP is the presence of a professional qualified in a therapeutic resource provided for in the NPICP, as described in Figure 1. Some professionals turn to the private sector for training in ICP, such as lato sensu postgraduate courses. This type of training can be a problem, as it tends to replicate educational models geared towards the reality of private practice, which do not meet the context of ICPs in PHC and the UHS<sup>24</sup>.

Faced with the need for qualifications for professionals, the Ministry of Health offers some distance learning courses in a virtual learning environment, which is a stimulus for those interested in the subject. Between 2014 and 2016, approximately 17,500 health professionals working in the UHS began training in ICP<sup>25</sup>. In this context, the following stand out: an 80-hour semi-presential course in auriculotherapy for higher-level health professionals in PHC, with regional hubs in 21 Brazilian states, since 2016<sup>26</sup>; a face-to-face course in integrative community therapy in the FHS / UHS; and a course in the use of medicinal plants and herbal medicines for CHAs, offered since 2017, with 73,431 students enrolled<sup>25</sup>.

State and municipal health departments are also being encouraged to offer continuing education to their professionals and/or specialization courses in ICP. This is a strategy that favors the presence and strengthening of the NPICP in the UHS<sup>27</sup>.

Expanding the dissemination of

information on the evidence for ICPs to professionals, managers, and users can also be seen as a favorable advance for the implementation of the NPICP in the UHS. The following virtual platforms stand out:

- a) Official website of the Ministry of Health (<https://aps.saude.gov.br/ape/pics>) - provides information such as the NPICP and other existing legislation and manuals; how to implement the NPICP; characteristics and objectives of the 29 approved practices; and statistical data<sup>28</sup>.
- b) *Observatório Nacional de Saberes e Práticas Tradicionais, Integrativas e Complementares em Saúde* (ObservaPICS) (<http://observapics.fiocruz.br/>) - a means of communication to share experiences and studies on ICPs with researchers, workers, managers and users of the UHS<sup>29</sup>.
- c) VHL in Traditional, Complementary, and Integrative Medicines (TCIM) (<http://mtci.bvsalud.org/pt/>) - specialized in the area of TCIM, it aims to promote open access to information and scientific evidence on this subject for researchers, managers, professionals, and students, to help them make decisions and exchange knowledge and give visibility to good experiences<sup>30</sup>. It is the result of the Brazilian Academic Consortium of Integrative Health (CABSIn) (<https://consorciobr.mtci.bvsalud.org/que-m-somos/>) - a collaborative network of researchers, universities (public and private), and research institutions from all over Brazil, to expand, disseminate and make more accessible the systematization of scientific evidence on TCIM and promote articulation between scholars in the field<sup>31</sup>.
- d) National Network of Social Actors and ICPS (RedePICS) (<https://redenacionalpics.wixsite.com/site/>) - created to establish channels of communication between PICs and various public institutions, as well as

promoting forums for debate, favoring articulation and interaction between the various actors<sup>32</sup>.

- e) Community of Practices (CoP) (<https://antigo.saude.gov.br/saude-indigena/cursos/674-assuntos/trabalho-e-educacao-na-saude/40531-comunidade-de-praticas-cdp>) - although it was deactivated in 2017, it was an important virtual space for building knowledge and learning by sharing the experiences of ICP professionals and managers<sup>33</sup>.

The inclusion of ICPs in a universal health system makes Brazil an outstanding reference point, which has led to the promotion of national and international cooperation to exchange experiences in the fields of care, continuing education, and health research<sup>28</sup>. As a result, the Ministry of Health has been invited to take part in various international agendas, promoted by the WHO and the Pan American Health Organization (PAHO), to exchange knowledge and practices on the subject<sup>22</sup>.

In 2008, the Ministry of Health and PAHO held the 1st International Seminar on Integrative and Complementary Health Practices in Brasilia, attended by representatives from five countries and the WHO. Experiences from Brazil, China, Cuba, Bolivia, Mexico, and Italy were presented and debated, contributing to the improvement of Brazilian policy<sup>10</sup>.

In 2009, Brazil and Mexico signed a cooperation agreement to exchange experiences and intercultural competence in the provision of health services. In 2011, a new cooperation agreement was signed to deepen exchanges in the areas of women's and men's health, humanization, and food and nutrition and health, as well as to learn more about local, municipal, and state initiatives to incorporate ICPs into the UHS<sup>28</sup>.

The 1st International Congress on ICPs, promoted by the Ministry of Health in 2018 in Rio de Janeiro, promoted national

and international discussions to integrate and exchange experiences between professionals and managers to deepen knowledge and discuss advances in ICPs<sup>34</sup>.

In light of the discussions with member countries, the WHO published the strategy on traditional medicine 2014-2023, which re-evaluates the strategic action plan of 2002-2005, establishing new guidelines. Three main objectives were highlighted: to encourage the implementation of national policies, to strengthen quality, safety, and efficacy by regulating products, practices, and professionals; and to promote universal coverage through the integration of these practices.<sup>1</sup>

Another national event that also favors this exchange of experiences is the National Congress of Integrative and Complementary Health Practices (CongrePICS), organized by WHO/PAHO to provide an environment for building knowledge, promoting dialogue between participants with different and diverse backgrounds who move through professional education, as well as users and leaders of traditional communities. The first edition of the congress took place in Natal-RN (2017), and the second in Lagarto-SE (2019).<sup>35</sup>

As a result of the COVID-19 pandemic, the National Health Council (NHC) recommended that the Ministry of Health, state and municipal health councils, and the Federal District include and publicize the appropriate use of ICPs in the treatment of the disease.<sup>36</sup> They are relevant to the care of patients and health professionals who, in the current scenario, are under intense stress, with a special emphasis on auriculotherapy, which is used to improve the physical and psycho-spiritual situation of these people.<sup>37</sup>

The use of medicinal plants favors comprehensive care in PHC, valuing popular knowledge and self-care. A study carried out in 2022 pointed to insufficient knowledge among health professionals about the NPICP and the use of plants for medicinal

purposes. Finally, the failure to address this content during the training of health professionals generates less knowledge, less research, and more prejudice due to lack of information, hindering the encouragement and dissemination to the community.<sup>38</sup>

Public policies are always under construction, but knowledge of the NPICP by professionals, users, and managers is essential for its implementation, which must take place through a collective planning process aimed at adapting actions to regional realities and needs.<sup>22</sup>

## Challenges

Even if backed by a national policy, the inclusion of a new health practice in the UHS represents a challenge for public managers and advocates of these medical rationalities.<sup>39</sup> With the publication of the NPICP, there was no additional financial investment by the Federal Government for its implementation, and it is one of the few national policies approved without its own budget. The expansion of the practices offered took place in an adverse political context, without public discussion about their relevance and potential level of effectiveness, involving many forms of care, some of which are little known.<sup>27</sup>

It is up to the municipal manager to draw up technical standards for the inclusion of the NPICP in the health network, define budgetary and financial resources for the implementation of ICPs, hire professionals, and define the practices to be offered.<sup>28</sup> Three specific procedures are paid for in the medium and high complexity block. In the pharmaceutical care block, herbal and homeopathic medicines are part of the list of medicines that can be purchased from the basic pharmaceutical care component.<sup>22</sup>

Even without inducing resources, some municipalities offer ICPs with their own funds.<sup>39</sup> Managers and health professionals point to the supply of materials and the acquisition of inputs as difficulties in

implementing ICPs in the UHS, limiting their expansion and access by users. A study that assessed the degree of implementation of ICPs in PHC in Santa Catarina considered the dimension of material resources to be regular and poor in 92.4% of the municipalities surveyed, which is reflected in the work of professionals and also hinders the expansion of ICPs.<sup>40</sup>

Given this context, it is necessary to make progress in guaranteeing medicines - homeopathic, anthroposophic, and herbal - and supplies - such as acupuncture and other traditional Chinese medicine techniques.<sup>22</sup> To expand the implementation of ICPs, the federal management of the UHS must ensure financial resources for their execution.<sup>41</sup> With the new model for transferring resources, Sus Legal, implemented in 2017, the transfer will be made in a single financial account that does not allow transfers to other accounts and the resource can only be spent on what has been planned.<sup>42</sup>

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made in a single financial account that does not allow transfers to other accounts, and the resource can only be spent on what has been planned.<sup>43</sup>

All health training courses must include the content of ICPs in their curricula to help strengthen the NPICP. It is possible that in this way, ICPs will become better known and practiced by UHS professionals, especially those in PHC. This is a way of helping to make these practices more respected, known, and available to the entire Brazilian population, solidifying the principles of the UHS and benefiting society as a whole.<sup>44</sup> There are specific undergraduate courses in certain ICPs, such as naturology.<sup>44</sup>

Some multiprofessional family health residencies have an ICP module. The São Paulo Health Department created the Multiprofessional Residency in ICP for Primary Care/Family and Community Health. A pioneer in the country, its guidelines include: strengthening PHC in the UHS; developing ICPs in a multidisciplinary way; consolidating ICPs in PHC; developing strategies for maintaining and recovering individual and collective health and quality of life; and articulating with the HCN.<sup>45</sup>

Concerning research and development in the area of ICP knowledge, an analysis was carried out by *ObservaPICS* in 2019, to characterize the research groups in Brazil that have projects or are studying ICP. In the first phase, 548 research groups related to the topic were identified, the majority (481) linked to public educational institutions. In the second phase, 300 (54%) of the 548 groups responded to the data collection instrument, of which 84 (28%) said they were carrying out research projects on ICPs in the UHS.<sup>29</sup> Although there has been an increase in work on ICPs in Brazil, there is still a need to expand new studies.<sup>46</sup> The Ministry of Health recognizes the need to increase incentives for research, especially into the efficacy, efficiency, effectiveness, and safety of ICP-based care.<sup>10</sup>

In the area of monitoring and evaluating the NPICP, producing, systematizing, and disseminating information on ICPs represents a major challenge. Efforts to monitor and analyze ICPs have great potential for improving the quality of services by designing possible solutions and reorganizing their activities.<sup>47</sup>

The NPICP's scope is undefined, favoring the inadequate recording of ICP information in UHS information systems. There are also technical registration problems, which is why there is a need to improve the systems and train professionals to operate them. These issues make it difficult to monitor and evaluate ICPs, weakening their consolidation.<sup>21</sup>

Monitoring and evaluating data on ICPs during the National Program for Improving Primary Care Access and Quality (PMAQ-AB) contributes to the management of the NPICP with relevant information on which NPICP practices are carried out in the UHS.<sup>21</sup> With the new PHC funding model, which began in January 2020, there will be no external evaluation of the PMAQ-AB<sup>48</sup>, which compromises the analysis of the NPICP's capillarity.

The hegemony of the current biomedical model, coupled with the market trend in health that transforms knowledge and practices into commodities, can be a barrier to the advances expected for these practices.<sup>49</sup> By prioritizing health promotion initiatives in PHC, the population has access to improvements in their health status. In this sense, ICPs have great potential for redefining the care model, in which users recognize health services as an instance of health promotion.<sup>50</sup>

## CONCLUSION AND IMPLICATIONS FOR PRACTICE

The growth in the implementation and use of ICPs around the world is notorious. Brazil is a leading country in the public health system, with PHC as its preferred entry point. Much progress has been made in the

implementation of ICPs, which is in the process of being expanded in the UHS.

ICPs are a form of health care that invests in prevention and promotion intending to prevent people from becoming ill. Concerning the implications for practice, they present an approach to the health-disease process and expanded medicine, which translates, especially in PHC services, into the potential for implementing the care model, as provided for in the National Primary Care Policy. When necessary, ICPs can also be used to treat and relieve symptoms in conditions where the illness has already set in.

In this way, for both users and professionals, ICPs have the potential to stimulate paradigm shifts in care. That's why all undergraduate and graduate health courses must include them in their content, as they will become better known and have the potential to be practiced in professional practice, increasing their availability to the Brazilian population, strengthening the principles of the UHS, and benefiting society as a whole.

For professionals already working in HCN health services, it is essential to develop ICP qualification strategies, in line with the principles and guidelines established for continuing education. There also needs to be a financial incentive to guarantee strategic inputs, and training in ICP for health professionals and managers, so that they can be sensitized to the issue.

It should also be noted that the monitoring and evaluation of ICPs depends, for the most part, on information system records which, due to the undefined scope of the NPICP, may be inadequate.

There are gaps in evaluations of ICPs in PHC. Future studies are needed to analyze the implementation of ICPs in different regions, as this measure can contribute to their continuous improvement and organization within the Brazilian health system.

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