Revista de Enfermagem
do Centro-Oeste Mineiro
2019;9:e3265
DOI:10.19175/recom.v9i0.3265
www.ufsj.edu.br/recom

Original Article

POLÍTICA NACIONAL DE PRÁTICAS INTEGRATIVAS E COMPLEMENTARES EM SAÚDE: DISCURSO DOS ENFERMEIROS DA ATENÇÃO BÁSICA

NATIONAL POLICY ON INTEGRATIVE AND COMPLEMENTARY HEALTH PRACTICES: DISCOURSE OF PRIMARY CARE NURSING

POLÍTICA NACIONAL DE PRÁCTICAS INTEGRADORAS Y COMPLEMENTARIAS EN SALUD: DISCURSO DE LOS ENFERMEROS DE LA ATENCIÓN PRIMARIA

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RESUMO

Objetivo: Analisar o discurso dos enfermeiros da Atenção Básica em relação à Política Nacional de Práticas Integrativas e Complementares de Saúde. **Método:** Trata-se de estudo descritivo com abordagem qualitativa, realizado com 14 enfermeiros das Estratégias de Saúde da Família. Para a coleta de dados foi utilizada uma entrevista semiestruturada, após a aprovação do Comitê de Ética e Pesquisa. **Resultados:** Percebeu-se o desconhecimento dos enfermeiros em relação à Política Nacional de Práticas Integrativas e Complementares de Saúde, em razão das lacunas no processo formativo e falta de educação permanente, porém os profissionais pontuaram as possíveis práticas que podem ser utilizadas no cuidado e evidenciou-se, como destaque, neste estudo, a orientação de plantas medicinais e fitoterápicos e certa confusão na diferenciação entre as mesmas. **Conclusão:** É necessário que exista o fortalecimento na formação acadêmica dos enfermeiros, diminuindo as lacunas existentes no aprendizado, por meio da inclusão de disciplinas e apoio da gestão, oferecendo ações de educação permanente, referentes a essas formas de cuidado no cenário da Atenção Básica.

Descritores: Terapias Complementares, Cuidados de Enfermagem, Atenção Primária à Saúde.

ABSTRACT

Objective: To analyze the discourse of Primary Care nursing regarding the National Policy on Integrative and Complementary Health Practices. **Method:** This is a descriptive study with a qualitative approach, which was performed with 14 nurses of the Family Health Strategies. A semi-structured interview was used to collect data, after the approval of the Research Ethics Committee. **Results:** Nurses were unaware of the National Policy on Integrative and Complementary Health Practices due to gaps in the training process and lack of continuing education. Nevertheless, the professionals highlighted the possible practices that could be used in care, with an emphasis being placed on the orientation of medicinal plants and herbal medicines, showing some confusion in the differentiation between them. **Conclusion:** There is a need to strengthen the academic training of nurses, reducing the gaps in learning, through the inclusion of subjects and management support by offering continuing education actions related to these ways of care in the Primary Care setting.

Descriptors: Complementary Therapies, Nursing Care, Primary Health Care.

RESUMEN

Objetivo: Analizar el discurso de los enfermeros de la Atención Primaria con respecto a la Política Nacional de Prácticas Integradoras y Complementarias de Salud. **Método:** Se trata de un estudio descriptivo con enfoque cualitativo conducido con 14 enfermeros de las Estrategias de Salud Familiar. Para la recolección de datos, se utilizó una entrevista semiestructurada, después de la aprobación del Comité de Ética e Investigación. **Resultados:** Se notó el desconocimiento de los enfermeros acerca de la Política Nacional de Prácticas Integradoras y Complementarias de Salud debido a lagunas en el proceso formativo y falta de educación continua, pero los profesionales señalaron las posibles prácticas que pueden ser utilizadas en la atención, haciendo hincapié en este estudio en la orientación de plantas medicinales y medicaciones fitoterapéuticas, mostrando alguna confusión en la diferenciación entre las mismas. **Conclusión:** Se hace necesario potenciar la formación académica de los enfermeros, disminuyendo las lagunas existentes en el aprendizaje, a través de la inclusión de asignaturas y apoyo de la gestión ofreciendo acciones de educación continua referentes a esas formas de atención en el escenario de la Atención Primaria.

Descriptores: Terapias Complementarias; Atención de Enfermería; Atención Primaria de Salud.

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Como citar este artigo:
Soares DP, Coelho AM, Silva LEAS, et al. Política Nacional de práticas integrativas e complementares em saúde: Discurso dos enfermeiros da Atenção Básica. Revista de Enfermagem do Centro-Oeste Mineiro. 2019;9:e3265. [Access_____]; Available in:_____. DOI: http://dx.doi.org/10.19175/recom.v9i0.3265

INTRODUCTION

Nursing care in health services has become increasingly complex, as it seeks the fullness of its actions with regard to health conditions. Thus, the National Policy on Integrative and Complementary Health Practices (NPICP)[1] seeks to integralize and broaden care in its biopsychosocial aspect.

The NPICP was approved and published in 2006, with the objective of acting in the fields of promotion, maintenance and recovery of health and prevention of diseases, through natural mechanisms, presenting an integral and humanized view of the subject in his health and disease process. We can also observed, based on this policy, the promotion of sensitive care from the inclusion of social participation and self-care, highlighting primary care (PC) as a scenario for the production of these practices[1].

Ministerial ordinances added na extension of Integrative and Complementary Health Practices (ICHP); the first Ordinance No. 971 of December 03, 2006, brought guidelines that contemplate and institutionalize in the Unified Health System (SUS), the offer of services and products of traditional Chinese/acupuncture medicine, homeopathy, medicinal plants and phytotherapy, social thermalism/crenotherapy and anthroposophic medicine[2].

In 2017, 14 more practices were added, including: art therapy, ayurveda, biodance, circular dance, meditation, music therapy, naturopathy, osteopathy, chiropractic, reflexotherapy, reiki, shantala, integrative community therapy and yoga[3]. And, in the year 2018, the newest ordinance was launched that includes new practices to the NPICP, such as aromatherapy, apitherapy, bioenergetics, family constellation, chromotherapy, geotherapy, hypnotherapy, hand laying, ozoniotherapy and flower therapy[4].

Despite the importance of the NPICP and its practices, there are still some obstacles, such as the difficulty in expanding access, offering and financing for the strengthening of these services, being little used in daily care, as a result of the precarious condition of human resources training to act in the ICHP and the lack of material resources and infrastructure for its realization[5].

Even with the deficit in daily care, the use of these practices has positive repercussions, studies confirm that patients who have the possibility of treatment with the ICHP, increase their quality of life, which confirms their success in the fragilities left in the health field by the fragmented paradigm of the biomedical model[6].

The Brazilian profession that became a pioneer in the recognition of alternative and complementary practices to be used by health professionals was nursing. In this conception of care practices, the nursing professional enables the exchange and construction of new knowledge, providing opportunities for the individual's own autonomy in relation to their health[7].

Therefore, to develop this study, we established the following guiding question: what is the discourse of Primary Care nurses in relation to the National Policy of Integrative and Complementary Health Practices?

This study presents the relevance of fostering the ICHP based on politics, contributing to the training of professionals and stimulating the use of these practices both by nurses and by the community, besides being an important tool to build a bond between the professional and the subject, for an active participation in their health process, as well as improving the care provided, serving for future reflections on the benefits of these forms of care in the daily life of PC.

Thus, the objective was to analyze the discourse of Primary Care nurses in relation to the National Policy of Integrative and Complementary Health Practices.

METHOD

The study has a descriptive nature with a qualitative approach. It was performed in the Primary Care of the municipality of Cajazeiras, in the state of Paraíba. This city is part of the 4th Macro-region of Health and the 9th Regional Health Management of Paraíba, currently presenting 19 Basic Health Units (BHU), consisting of 23 Family Health Teams registered.

The participants of this study were 14 nurses who compose the 23 Family Health Teams in the municipality of Cajazeiras. The inclusion criterion used was having worked for more than 12 months as a nurse in the PC, understanding that this is a satisfactory period to establish the bond with the dynamics of this care scenario. Exclusion criteria were: being on vacation, on leave-health or away from the service. The final number of participants, after the identification of the theoretical saturation of data collection was 14.

Data collection occurred between the months of May and June of 2017 and was carried

out by means of an individual interview, in a private place reserved at the BHU in which the nurse acted, with an average duration of 10 minutes, by means of a semi-structured questionnaire with open questions aimed at nurses' knowledge about NPICP, its characteristics and its accomplishment in daily care.

After the collection, ordering and organization of the data generated through semi-structured interviews, we used the Collective Subject Discourse (CSD) as a methodological process for data analysis, which is a method that enables the thought representation of a certain community.

The CSD proposes the sum of ideas, in a non-numerical way, which methodologically operationalized express the thought of a particular group through discourse. The CSD is understood as a project of organizing and tabulating qualitative information of a verbal nature, obtained from testimonies that basically analyzes the verbal material collected to extract the main ideas (MI) and their corresponding Key Expressions (KE). These testimonies will compose the raw material, in the form of one or several speeches-syntheses in the first person singular, better saying, in the first (collective) person of the singular, where, evidences the presence of the individual of the discourse and at the same time that, it makes a collective reference, because this individual being speaks in the name of a community[8].

The investigation was initiated after approving the project by the Research Ethics Committee (CEP) of the Federal University of Campina Grande (UFCG), Campus of Cajazeiras, under the number of opinion 2,012,802. The participation in the study was carried out through the signature of the respondent in the Informed Consent Form (ICF), elaborated in two copies, signed by the participant of the interview and by the researcher responsible. Respecting the resolution 510/2016 of the Ministry of Health, the ethical and legal components are present in all stages of the research, confirming the participants confidentiality and privacy of the information that were collected, assuring them their use for scientific and academic purposes.

RESULTS AND DISCUSSION

This research was carried out with a total of 14 nurses in the PC of Cajazeiras city, Paraíba. Regarding the profile of the participants, there was female predominance, being 11 females and three males. The majority (10) had more than five years of graduates, however, it is noteworthy that eight had less than five years of experience in the HBU. It is also worth mentioning that only one of the interviewees was graduated, the others had studied specializations, mostly (eight) in family health.

Regarding the policy, nurses demonstrate nt knowing it, although they use some ICHP, even without theoretical basis. We identified three main categories, which will be exposed and analyzed with their respective CSD. The first category presents the lack of knowledge of the nurses regarding the policy of ICHP, exposing three central nuclei of ideas, the deficit in the knowledge of the ICHP, the absence of this policy in the formative process and lack of training courses. The second category identifies the ICHP as a possibility of multidimensional care, generated from a central nucleus, the identification of the best known practices and their objectives. The third category discusses medicinal plants and phytotherapics as a possibility of production in the daily care of nurses, gathering three central nuclei of ideas, the difficulty in differentiating the practice of phytotherapy and medicinal plants, the benefits of using this therapy and the reduction of population costs.

The first category presents the lack of knowledge of the nurses regarding the policy that addresses the ICHP, developed from the interviews of ten nurses, as shown below:

Category 01-Lack of knowledge of the National Policy of Integrative and Complementary Health Practices.

CSD 01 - "What is the policy itself? I can't tell you what it is, I don't remember that policy, because it's not practiced in the sector where I work. This policy is not implemented here in the FHP, because I really do not know the several practices that we could use. I've heard about it, but I've never read about the practice and we don't apply this policy in the unit, I've heard about the policy, I didn't know what it was about, but I had heard, I never got to do, I have no training for that. It is more the lack of information that we have about this, when we go to the field of work, we feel difficulties to put into practice because we have no knowledge, we did not study them as na obligatory or complementary subject, and in day-to-day practice we end up putting

these issues aside. We never received training, and it is also my fault, I never read the policy itself, what rules it, what is allowed, what is not, for the field of work the reality is different, they are activities or practices that are not exactly in the day to day of the health unit".

It is obvious there is a deficit in relation to NPICP n this CSD, due to the unfilled gaps in the training process of the nurse, in their undergraduate period, as well as due to the absences of training offered by the management, through permanent education, which reverberates negatively in the daily care practice of this professional, who does not offer, to the population of their region, actions that allow a look beyond the traditional clinic, complaint-conduct, prescriptive and medical.

This situation is evident in the study on the situation of the ICHP in undergraduate health courses in the country. This research shows that only 23 out of the 87 public institutions of higher education in nursing analyzed, offered subjects related to ICHP. Moreover, of the few that offer them, 17 do so in an optional way, that is, most nurses are graduating without a domain about ICHP, so they are not confident security for its implementation[7].

Confirming the findings of this investigation, a study carried out in the Family Health Units (FHU) in João Pessoa, Paraíba, showed that all the nurses interviewed showed lack of knowledge regarding ICHP, which further revealed the lack of preparedness of the nurse, either in undergraduation, post-graduation or by the shortage of training and specialization courses[9].

Another study carried out at a HBU in São Paulo found that about 56.5% of the 70 professionals participating in the study, were unaware of the ICHP, and regarding the professional training associated with the ICHP, it detected that 68.2% of the professionals did not have qualifications on the subject. About training courses on ICHP, 76.8% did not receive any qualification after they started working[10].

Thus, it is obvious that, after graduation, professionals are sometimes stalled in conventional practices and are involved in an environment of lack of scientific basis and understanding of public policies[11]. This situation fosters the decrease in the effectiveness of ICHP and its practices in the PC field[12].

Therefore, it is necessary to incorporate the ICHP into academic subjects, as well as in permanent education or courses so that the professionals could feel able to perform these therapies in the integrality of care[13,14].

Even though the policy objective is to strengthen PC, with actions aimed at the prevention of diseases and health promotion and recovery, ICHP, as highlighted in the CSD, are still unnoticed in the nurse's daily care. Therefore, instituting movements are necessary, both in training spaces with the inclusion of subjects to awake academics and professors and in the work environments with emphasis on the PC, in the search for training and sensitization of these professionals about the importance of the ICHP for consolidating most effective, humanized and ethical care.

The second category was carried out with the participation of nine nurses and presents ICHP based on the nurses' view:

Category 02- Integrative and Complementary Practices as a possibility of multidimensional care

CSD 02 - "They are practices that help the patient to relax, help the patient to forget some of the pain. They are well acquired by the body, so that they have a more adequate health. You can make use of teas, medication with herbal medicines, sleeping pills, yoga, right?! Acupuncture that uses those needles to activate some areas of the nervous system, that treat, right?! Some diseases such as stress, kidney problems, neurological problems, they are used for asthma. There are also songs to try to relax, understand? It's called music therapy. I have also seen the integration in backyards, where the community planted medicinal plants in the backyards to be used by them, right?! This homeopathic part among others tha has to do with the disease health process and the practices of self-care. They are geared towards what is not a curative model, potentializing these actions is important to use less medicines".

We can identify, in this CSD, that even with the lack of knowledge of ICHP, the nurses talk about possible therapies that can be performed with the ICHP, but in a reduced scale, because the nurses identify the best known and teir objectives practices, indicating that the greatest difficulty is on what rules the policy and the search for updates of the ordinances that include new therapies.

Even though, the nurses manage to make the connection that these practices have with the

body and mind and that sometimes even in a timid way, they express that care, through those practices, should encompass the whole of the user, that is, the singularity and especially the subject's multidimensionality.

There are several possibilities of application of the ICHP in care, taking into account the essence of integral care, but it is necessary to broaden the knowledge and dissemination about its indications, efficacy and management, besides the investment in research in the area. These practices are very useful considering the vision of active and total care, since they complement conventional treatment and provide assistance that cover physical, psychological and emotional aspects, as well as improve the subject's quality of life[15].

Analyzing some practices mentioned by nurses of this CSD, a study showed the benefit of acupuncture in patients with chronic low back pain, where 40% of those using this practice, totally suspended analgesics consumption[16].

An integrative review showed that music therapy presents several positive results, among them, both in physiological factors in relation to the reduction of anxiety, pain, stress, depression, mental confusion, psychotic symptoms, levels of blood pressure and better quality of sleep, as in psychosocial factors such as increased satisfaction and quality of life, promoting relaxation and well-being and improving interpersonal relations[17].

It is noteworthy, also, as a successful experience, community gardens in a HBU with positive impacts, showing improvements in the professional-user relationship, besides promoting dialogue on self-care, healthy eating, reduction of excessive self-medication and the incentive of herbal medicines and the use of medicinal plant[18].

A study conducted with elderly people using the ICHP indicates the improvement in quality of life, in relation to self-esteem, pain relief, hypertension control, increased balance, improvement in disposition and social relations, strengthening of muscle and bone structures, in addition to decreasing drug consumption[19].

Thus, it identifies a series of benefits of the several types of ICHP addressed in the CSD, such as phytotherapy, acupuncture, music therapy, among others, aiming at the qualification of care, with the strengthening of the bond between the health professional and the user, consolidation of the dialogued relationship between the subjects involved in the therapeutic plan, as well as the protagonism of the social actor in their self-care, encouraging, therefore, the reorientation of the health care model beyond the biologistic practices.

Finally, the third category discusses the use of medicinal plants and phytotherapics that, even with a subtle discourse, presents the possibility of care in the routine of nurses at the PC. To produce CSD in this category, 11 nurses participated:

Category 03-medicinal and phytotherapic plants as a possibility of production in the daily care of the nurse.

CSD 03 - "I try to orientate about herbal medicine, not in its completeness, but focused on the use of herbs, right?! It would be the phytotherapics, that one, I think it's more or less that. Given that it is a therapy that uses medicinal plants, right?! This issue of using phytotherapics I think it is very useful, "lambedores", teas. We guide, for example, with respect to the use of herbs, some herbs we say, or some are, specific legumes, which I remember a lot, for example, "chuchu", which I highly recommend to hypertensive patients. We're thinking about making a medical garden, right? Medicinal plant medication, in patients, could actually bring benefits, perhaps much more than laboratory medications. There are several things that we can use, which is cheaper, as it says, that it would be very beneficial and it does not need so much material and that it is more accessible."

Although nurses are unaware of the ICHP, we can see that the use of medicinal plants and phytotherapics ends up emerging in the CSD, even in a subtle way, highlighting this therapy in the possibility of care.

There are several benefits of using medicinal plants and phytotherapy as: strengthening the bond between the community and the health team; mutual exchange of knowledge; co-responsibility, through the promotion of autonomy; construction of knowledge about the medicinal plants generated by the professional-user interaction and empowerment of the subject as a social actor. Other advantages that are also observed with the use of medicinal plants and phytotherapy from their use are: possibility of excessive reduction of medicalization; strengthening the principle of integrity; increased therapeutic resources and care offerings[20].

Another finding is that there is some confusion in the nurses' discourse, since we perceived that these professionals are able to distinguish the use of medicinal plants and phytotherapics and sometimes nurses fail to differentiate them, expressing that the way to use and guide each of these practices is the same.

The National Program of Medicinal Plants and Phytotherapics (NPMPP)[21] establishes the difference in which medicinal plants are plant species under cultivation or not, capable of relieving symptoms and curing diseases. Phytotherapics are industrialized drugs that obtain their products from medicinal plants.

Corroborating this finding, in a study some nurses mention the orientation and application of medicinal plants and phytotherapy, despite little knowledge, lack of training and difficulty in understanding phytotherapy. This situation points to the need for professional qualification, since the majority reports not being prepared, during the academic period and the professional life, since there are not possibilities of training courses for this type of care[9].

Thus, it is notorious the impact that the reduced knowledge about the use of medicinal plants and phytotherapics can bring. Therefore, it is of paramount importance that the health professional has knowledge in the realization of practices with medicinal plants and phytotherapics to avoid the misuse and erroneous use of the population, thus decreasing the cases of intoxication and greater damage to health[22]. It is noteworthy that the most appropriae professional to demystify the use and make the population sensitive to the use of these ICHP is the nurse.

Adding to this thought, most professionals are not prepared to use medicinal plants or prescribe phytotherapics for the population, in their daily practice, but this action can become viable and beneficial, due to the reduction of costs in the PC[23]. Strengthening this idea, another study show that health professionals affirm that ICHP with emphasis on medicinal and phytotherapic plants are useful therapeutics in the care process, due to the relative low cost, which facilitates the population access[24], which can be positive reinforcement in the traditional therapeutic plan by adding new and accessible therapeutic measures[25].

It is noteworthy, finally, that in the region where this research was carried out, high Sertão Paraiba, there are a variety of plants that, with structured training in permanent education and scientific basis could be used in the production of care, stimulating the rupture with the practice based only in the traditional drug treatment.

FINAL CONSIDERATIONS

During this study, we analyzed the discourse of the PC nurses in relation to the ICHP. We prioritize this scenario of attention, due to the preference of the application of the ICHP, in which the user becomes active subject in the production of their own health, despite being a form of care transversal to any scenario of attention.

In the course of the analysis, the lack of knowledge of the nurses in relation to the ICHP was noticeable due to gaps in the formative process and lack of permanent education, reflecting in the absence of scientific basis to act with these practices in daily care.

In this study, it was also possible to identify the characteristics of the ICHP, in which the professionals punctuated the possible therapies that can be used in care, realizing that they increase the bond between professional and user and improve the quality of care in PC.

Another pertinent finding was the orientation of medicinal plants and phytotherapics, which positively affects the decrease of self-medication and the reduction of expenditures. However, there was a certain confusion among the interviewees in differentiating these practices, which may lead to incorrect orientation, causing harm to the user.

It is noteworthy that the results obtained in this study have limitations, since it is not able to generalize its findings, due to the fact that the investigation was carried out in a municipality, which involves cultures, knowledge and beliefs different from other places in the country. In addition, lack of confidence is indicated as a difficulty and the cause of the initial refusal by some nurses to answer the guiding questions of this study, requiring greater dialogue and exposure of relevance, as well as positive repercussions for their practices, so that they could participate in the research. Despite a good response, five nurses refused to participate in this investigation.

Finally, it is worth noting that this research adds a new look in relation to the ICHP, and brings contributions for theoretical and practical purposes of the theme, considering it as a new research instrument, with the aim of seeking

improvements in the assistance of nurses in PC, thus generating greater search for other forms of care that are not focused on curativism, expanding the conceptions of health and care of the population.

We suggest that further studies are developed in the area of the ICHP, both in other regions and also in the various areas of health and with other social actors. Aiming at the greater dissemination and credibility of these practices, expanding their implementation and deployment, in order to transform the present reality.

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Note: This study represents an excerpt from the Course Completion Monograph titled "Integrative and Complementary health practices in primary care: Nurses Discourse analysis" of the Teacher Training Center, Federal University of Campina Grande, as a requirement to obtain a Bachelor's degree in Nursing.

Received in: 29/01/2019
Approved in: 19/08/2019

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