Integrative and complementary practices: use by community health agents in self-care

Práticas integrativas e complementares: utilização por agentes comunitários de saúde no autocuidado

Prácticas integradoras y complementarias: utilización por agentes comunitarios de salud en el autocuidado

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ABSTRACT

Objective: To verify the use of integrative and complementary practices (ICPs) by community health agents working in family health teams. **Methods:** Cross-sectional, quantitative research, conducted in the city of Montes Claros, Minas Gerais. An structured form was used for the characterization of participants and use of ICPs. Descriptive and bivariate analyses were conducted. **Results:** Use of ICPs was referenced by 94 (40.7%) agents. The use of medicinal plants was predominant (32.5%). There were associations between: ICPs in general and negative self-perception of health (p=0.032), homeopathy and higher education (p=0.015), massage and living with partner(p=0.024), chiropractic care and income equal to or greater than four minimum wages (p=0.031), relaxation/meditation and religion (p=0.028). **Conclusion:** The use of ICPs was verified in the healthcare of community agents. It is necessary to strengthen these practices for the promotion of health and prevention of diseases.
Descriptors: Complementary Therapies; Community Health Workers; Family Health; Primary Health Care; Community Health Nursing.

RESUMO

Objetivo: Verificar a utilização de práticas integrativas e complementares (PICs) por agentes comunitários de saúde atuantes nas equipes de saúde da família. **Método:** Pesquisa transversal, quantitativa, realizada na cidade de Montes Claros, Minas Gerais. Utilizou-se formulário estruturado para caracterização dos participantes e do uso de PICs. Foram conduzidas análises descritiva e bivariada. **Resultados:** A utilização de PICs foi referida por 94 (40,7%) dos agentes. Predominou o uso de plantas medicinais (32,5%). Houve associações entre: PICs no geral e autopercepção negativa da saúde (p=0,032), homeopatia e ensino superior (p=0,015), massagem e viver com companheiro (p=0,024), quiropraxia e renda igual ou superior a quatro salários mínimos (p=0,031), relaxamento/meditação e ter religião (p=0,028). **Conclusão:** O uso de PICs foi verificado no cuidado em saúde dos agentes comunitários. É preciso fortalecer essas práticas para a promoção da saúde e prevenção de agravos.
Descritores: Terapias Complementares; Agentes Comunitários de Saúde; Estratégia Saúde da Família; Atenção Primária à Saúde; Enfermagem em Saúde Comunitária.

RESUMEN

Objetivo: Verificar la utilización de prácticas integradoras y complementarias (PICs) por agentes comunitarios de salud actuantes en los equipos de salud de la familia. **Método:** Investigación transversal, cuantitativa, realizada en la ciudad de Montes Claros, Minas Gerais. Se utilizó formulario estructurado para caracterización de los participantes y del uso de las PICs. Se realizaron análisis descriptivos y bivariados. **Resultados:** La utilización de las PICs fue referida por 94 (40,7%) de los agentes. Predominó el uso de las plantas medicinales (32,5%). Hubo asociaciones entre: las PICs en general y la autopercepción negativa para la salud (p=0,032), la homeopatía y la educación superior (p=0,015), el masaje y la vida en pareja (p=0,024), la quiropraxia y el ingreso igual o menor que cuatro salarios

mínimos (p = 0,031), la relajación/meditación y tener una religión (p = 0,028). **Conclusión:** El uso de las PICs fue verificado en el cuidado en salud de los agentes comunitarios. Es necesario reforzar estas prácticas para la promoción de la salud y prevención de enfermedades. **Descriptores:** Terapias Complementarias; Agentes Comunitarios de Salud; Estrategia de Salud Familiar; Atención Primaria de Salud; Enfermería en Salud Comunitaria.

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INTRODUCTION

Integrative and complementary practices (ICPs) consist of systems and resources that seek to stimulate natural damage-preventing mechanisms and health recovery through effective and safe technologies. They focus on the receptive listening, development of a therapeutic bond and the integration of human beings with the environment and the society. Other points shared by the various approaches provided by ICPs are the extended overview od the health-disease process and the global promotion of human care, especially the self-care[1]. In contemporary times, in addition to the traditional medicine, ICPs represent different forms of diagnosis and care within several health practices[2-3]. In many countries, an increased demand and use of these practices have been noticed[4].

ICPs can be valuable resources for health promotion, notably by imposing a new understanding of the health-disease process, in a more holistic and empowering manner, with positive impacts on the daily lives of patients. However, to potentialize them in the Unified Health System (SUS) and in the integral care to the health of the population, the challenges of their organization and expansion within the services must be overcome, especially from the Primary Health Care (PHC)[3]. In Brazil, only recently the ICPs were standardized in the public sector, after the approval of the National Policy of Integrative and Complementary Practices (PNPIC)[1]. The knowledge about their se is still scarce, especially regarding health professionals.

Community Health Agents (CHA) represent an increasing segment of health professionals in the PHC. They take on a remarkable significance considering their work dynamics of monitoring patients registered in the Family Health Strategy (FHS) teams. The CHA act as a link between the health teams and the population, focusing on a gap between scientific knowledge and experience, thus reducing the boundaries between patient and family health team [5-6]. In the national and international literature, the CHA is regarded as a nuclear element in family health actions, and studies recognize them as essential professionals for the reorientation and consolidation of PHC[7-13].

The everyday work of CHA and their working process in health involve considerable complexity and pressure arising from the demands of team, managers, and the community surrounding them[6]. This leads to a risk environment for developing physical and mental wear due to situations that may generate dissatisfaction, discouragement, tiredness, fatigue, stress, anxiety and exhaustion[6,14]. In this sense, the CHA are faced with the need to develop strategies to counter the difficulties of their job and, thus, they may impose self-care measures that help them keep and/or promote their health[15]. Among such mechanisms, the ICPs may be included.

In this sense, the necessity and relevance of knowledge on the use of ICPs by the CHA is evidenced because, in addition to representing an important group of health professionals, they disseminate information on health and serve as a model for the community. Furthermore, there is a lack of previous research on this subject. Such scientific evidence gaps lead to the conduct of more research, to obtain knowledge to subsidize health practices guided towards the inclusion of ICPs in the health care.

OBJECTIVE

To verify the use of integrative and complementary practices by community health agents working in family health teams.

METHOD

Ethical aspects

All ethical aspects ere in accordance with Resolution No. 466 of December 12, 2012, of the National Health Council. The research project was approved by the Research Ethics Committee. Authorization from the Head of the Division of Basic Care was also obtained. Participants read and signed the Informed consent form.

Study design, location and period

This is a quantitative cross-sectional study. It was conducted in the city of Montes Claros, situated in the northern part of the State of Minas Gerais (MG) – Brazil, from December 2012 to May 2013.

Population or sample; inclusion and exclusion criteria

In 2012, the municipality had a total of 450 CHA, working within 76 family health teams, being 10 in the rural area and 66 in the urban area. The target population was composed by the 365 CHA operating in family health teams within the urban area of the city. Sample size was calculated considering the following parameters: prevalence of 0.10 of ICPs use[16], 95% confidence interval, and accuracy level of 5%. A correction factor of 1.5 was adopted for the design effect (*deff*). Calculations showed the need to interview at least 192 CHA.

For the selection of participants, a random drawing of urban census tracts of Montes Claros was held. Later, the CHA of the teams belonging to each sector drawn were invited to participate in the study. Successive draws were held until the number of CHA was achieved. According to the draws made, 61 of the 66 family health teams located in the urban area of the city were visited. Participated in the research those who were operating in the FHS selected for at least six months. Were excluded from data collection the CHA who were on vacation, certificate, sick or maternity leave.

Study protocol

Data collection was carried out by scholars of the health field between December 2012 and May 2013, in the health units where the research participants worked, in a secluded

environment. Days and times most convenient for the respondents were scheduled according to the teams' availability and authorization from the coordination.

For data collection, a questionnaire covering sociodemographic (gender, age, marital status, self-declared ethnicity, religion, education level, family monthly income, family arrangement), occupational (time of performance as CHA, absences to work in the last years), and health-related (impact of the work on health, self-perception of health state) variables and the use of IPCs. The IPCs investigated included: use of acupuncture, homeopathy, medicinal plants, massage, orthomolecular medicine, chiropractic, and relaxation/meditation[1].

Analysis of results and statistics

Data were organized at a database of the Statistical Package for the Social Sciences (SPSS) software for Windows, version 18.0. A descriptive analysis of the variables was performed through absolute and relative frequency. In the association analysis, were regarded as dependent variables: use of ICPs (the use of at least one of the practices investigated was considered a "yes," whereas the self-report of not using any of these practices was a "no"); acupuncture (yes and no); homeopathy (yes and no); medicinal plants (yes and no); massage (yes and no); orthomolecular medicine (yes and no); chiropractic (yes and no), and use of relaxation/meditation (yes and no).

The independent variables were the sociodemographic, occupational, and health-related variables, thus categorized: self-declared ethnicity (white and non-white); religion (yes or no); education level (some/complete higher education and up to high school), and monthly family income ($\geq$ and $<$ four minimum wages). Bivariate analyses were conducted through the chi-square test, to assess the association between each one of the dependent and independent variables, considering a significance level of $p \leq 0,05$.

RESULTS

In this study, 231 CHA participated, being most female (85.3%), with a mean age of 33.39 years ($\pm$ 8.98) and education level up to high school (61.9%). As for the performance as CHA, most (64.5%) exercised this function for more than three years. The self-report that work impacts on health was predominant (81.4%) and negative self-perception of health was referenced by most participants (48.9%) (Table 1).

The use of PICs was referenced by 94 (40.7%) of the CHA. Prevalence in use of medicinal plants was observed (32.5%), followed by massage (9.1%), and relaxation and meditation (5.6%) (Table 2).

Regarding the association between the use of integrative complementary practice in general, of each specific practice, and the characteristics of the ACS, during bivariate analysis the following statistically significant associations were observed: ICPs and negative self-perception of health (p=0.032), homeopathy and higher education (p=0.015), massage and living with partner (p=0.024), chiropractic care and income equal to or greater than four minimum wages (p=0.031), relaxation/meditation and religion (p=0.028) (Table 3).

Table 1 – Characterization of Community Health Agent, Montes Claros, Minas Gerais, Brazil, 2013 (N = 231)

Variables	n	%
Sociodemographic		
Gender		
Female	197	85.3
Male	34	14.7
Age*		
Under 40 years old	173	74.9
40 years or older	58	25.1
Marital status		
Without partner	109	47.2
With partner	122	52.8
Self-declared ethnicity		
White	42	18.2
Mixed-race	140	60.6
Black	45	19.5
Yellow (Asian)	04	1.7
Religion		
Catholic	148	64.1
Evangelic	68	29.4
Other	06	2.6
Without religion	09	3.9
Education level		
8th grade or less	07	3.1
Some high school	05	2.2
High school	131	56.7
Some higher education	53	22.9
Higher education degree	35	15.1
Monthly household income**		
Less than 1 minimum wage	03	1.3
1 to 3 minimum wages	183	80.6
More than 4 minimum wages	41	18.1
Family arrangement		
Lives with 4 or more people	96	41.6
Lives with 0 to 3 people	135	58.4
Occupational		
Time of performance as CHA***		
1 to 3 years	82	35.5
> 3 years	149	64.5
Absences to work on last year		
No absences	122	52.8
At least one absence	109	47.2
Health-related		
Impact of work on health		
No	43	18.6
Yes	188	81.4
Self-perception of health state		
Positive	118	51.1
Negative	103	48.9

*Note: *Presence of missing (n = 221); **Presence of missing (n = 227); ***CHA: Community Health Agent.*

Table 2 – Description of the use of integrative and complementary practices by Community Health Agent, Montes Claros, Minas Gerais, Brazil, 2013 (N = 231)

Use of integrative and complementary practice	n	%
Integrative and complementary practices		
Yes	94	40.7
No	137	59.3
Acupuncture*		
Yes	5	2.2
No	225	97.8
Homeopathy		
Yes	11	4.8
No	220	95.2
Medicinal plants		
Yes	75	32.5
No	156	67.5
Massage		
Yes	21	9.1
No	210	90.9
Orthomolecular Medicine		
Yes	3	1.3
No	228	98.7
Chiropractic		
Yes	3	1.3
No	228	98.7
Relaxation/Meditation		
Yes	13	5.6
No	218	94.4

Note: *Presence of missing (n = 230).

DISCUSSION

This study demonstrated the use of ICPs amongst the CHA in the municipality of Montes Claros - MG. The use of at least one of these practices was mentioned by almost half of these workers. When considering the use of each ICP individually, lower adherence to their majority was observed, except in the case of medicinal plants, used by almost one-third of respondents.

In population-based research, when all practices mentioned were considered, the frequency was of 8.93%[16], quite lower than that observed in this study. However, among professionals of public health services from the Brazilian municipalities of Itumbiara and Panamá (Goiás) and Araporã (Minas Gerais), 99.2% reported having already used at least one practice[17], result higher than that of this study. Regarding national tendencies, research on supply and production ICP care in SUS in the municipalities of Campinas (São Paulo), Florianópolis (Santa Catarina) and Recife (Pernambuco) revealed still gradual growth of their use and implementation in local public healthcare systems[18]. When analyzing each ICP individually, the percentage use of medicinal plants, massage, relaxation/meditation, homeopathy, orthomolecular medicine and acupuncture was higher than a previous study conducted with the population of the municipality of Montes Claros - MG[16]. In a study conducted with professionals of public health services, the use of acupuncture was higher[17].

The extensive use of medicinal plants by CHA observed in this study may be justified partially due to the traditional and popular usage of this practice in Brazil, with historical origins that managed to endure time[17]. Another explanation would be its low cost[16]. It is also worth mentioning that the northern

Table 3 – Result of the bivariate analysis between integrative and complementary practices and independent variables among Community Health Agent, Montes Claros, Minas Gerais, Brazil, 2013 (N = 231)

Independent variables	Integrative and complementary practice used n (%)							
	ICPs*	Acupuncture	Homeopathy	Medicinal plants	Massage	Orthomolecular Medicine	Chiropractic	Relaxation/ Meditation
Gender								
Female	81 (86.2)	50 (100.0)	10 (90.9)	65 (86.7)	20 (95.2)	3 (100.0)	3 (100.0)	11 (84.6)
Male	13 (13.8)	0 (0.0)	1 (9.1)	10 (13.3)	1 (4.8)	0 (0.0)	0 (0.0)	2 (15.4)
P value	0.752	0.588	0.589	0.680	0.177	0.469	0.469	0.944
Age								
< 40 years old	72 (76.6)	3 (60.0)	9 (81.8)	58 (77.3)	15 (71.4)	2 (66.7)	3 (100.0)	11 (84.6)
≥ 40 years or older	22 (23.4)	2 (40.0)	2 (18.2)	17 (22.7)	6 (28.6)	1 (33.3)	0 (0.0)	2 (15.4)
P value	0.621	0.628	0.587	0.553	0.701	0.741	0.313	0.405
Marital status								
Without partner	41 (43.6)	2 (40.0)	5 (45.5)	34 (45.3)	5 (23.8)	1 (33.3)	1 (33.3)	7 (53.8)
With partner	53 (56.4)	5 (60.0)	6 (54.5)	41 (54.7)	16 (76.2)	2 (66.7)	2 (66.7)	6 (46.2)
P value	0.368	0.604	0.906	0.696	0.024	0.629	0.629	0.620
Self-declared ethnicity								
White	18 (19.1)	0 (0.0)	1 (9.1)	17 (22.7)	1 (4.8)	1 (33.3)	1 (33.3)	1 (7.7)
Nonwhite	76 (80.9)	5 (100.0)	10 (90.9)	58 (77.3)	20 (95.2)	2 (66.7)	2 (66.7)	12 (92.3)
P value	0.752	0.504	0.423	0.220	0.094	0.493	0.493	0.313
Religion								
Has a religion	89 (94.7)	5 (100)	11 (100)	71 (94.7)	20 (95.2)	3 (100.0)	3 (100.0)	11 (84.6)
Does not have a religion	5 (5.3)	0 (0)	0 (0)	4 (5.3)	1 (4.8)	0 (0.0)	0 (0.0)	2 (15.4)
P value	0.355	0.883	0.494	0.434	0.830	0.726	0.726	0.028

Table 3 (concluded)

Independent variables	Integrative and complementary practice used n (%)							
	ICPs*	Acupuncture	Homeopathy	Medicinal plants	Massage	Orthomolecular Medicine	Chiropractic	Relaxation/ Meditation
Education level								
Higher education/some higher education	36 (38.3)	4 (80)	8 (72.7)	30 (40.0)	8 (38.1)	2 (66.7)	2 (66.7)	6 (46.2)
Up to High School	58 (61.7)	1 (20)	3 (27.3)	45 (60.0)	13 (61.9)	1 (33.3)	1 (33.3)	7 (53.8)
P value	0.958	0.111	0.015	0.679	1.000	0.305	0.305	0.538
Monthly income								
≥ 4 minimum wages	18 (19.1)	1 (20.0)	3 (27.3)	15 (20.0)	3 (14.3)	1 (33.3)	2 (66.7)	4 (30.8)
< 4 minimum wages	76 (80.9)	4 (80.0)	8 (72.7)	60 (80.0)	18 (85.7)	2 (66.7)	1 (33.3)	9 (69.2)
P value	0.863	0.889	0.450	0.708	0.593	0.510	0.031	0.246
Working time as CHA**								
1-3 years	35 (37.2)	3 (60.0)	4 (36.4)	32 (42.7)	8 (38.1)	2 (66.7)	2 (66.7)	6 (46.2)
> 3 years	59 (62.8)	2 (40.0)	7 (63.6)	43 (57.3)	13 (61.9)	1 (33.3)	1 (33.3)	7 (53.8)
P value	0.648	0.391	0.951	0.114	0.794	0.256	0.256	0.409
Impact of work on health								
No	16 (17.0)	0 (0.0)	0 (0.0)	12 (16.0)	3 (14.3)	1 (33.3)	0 (0.0)	2 (15.4)
Yes	78 (83.0)	5 (100.0)	11 (100.0)	63 (84.0)	18 (85.7)	2 (66.7)	3 (100.0)	11 (84.6)
P value	0.606	0.494	0.104	0.479	0.593	0.510	0.404	0.758
Absences to work on last year								
No absences	43 (45.7)	2 (40.0)	4 (36.4)	33 (44.0)	11 (52.4)	2 (66.7)	3 (100.0)	5 (38.5)
At least one absence	51 (54.3)	3 (60.0)	7 (63.6)	42 (56.0)	10 (47.6)	1 (33.3)	0 (0.0)	8 (61.5)
P value	0.075	0.479	0.263	0.063	0.967	0.629	0.099	0.286
Self-perception of health state								
Positive	40 (42.6)	1 (20.0)	4 (36.4)	35 (46.7)	7 (33.3)	1 (33.3)	2 (66.7)	6 (46.2)
Negative	54 (57.4)	4 (80.0)	7 (63.6)	40 (53.3)	14 (66.7)	2 (66.7)	1 (33.3)	7 (53.8)
P value	0.032	0.217	0.317	0.352	0.088	0.536	0.587	0.714

Nota: *PICs: práticas integrativas e complementares; **ACS: Agente Comunitário de Saúde.

region of MG is characterized by a culture and tradition of using medicinal plants, with easy access to different kinds of plants cultivated *in loco*[19]. The use of medicinal plants is in line with the proposals of the World Health Organization (WHO)[20].

However, it must be considered that this practice has been undervalued in the country due to the supremacy of a paradigm that sees healthcare as centered into biomedical technologies. This makes the use of medicinal plants seem like a remnant of a form of care from underdeveloped, primitive and archaic times, and not as a possible future of new sustainable technologies[21].

Although the WHO encourages the ICP valorization and recognizes them as useful therapeutic resources that can contribute to the local public healthcare system[4,20], in Brazil the increase in ICP usage by the general population faces the following challenges: reduced amount of trained human resources; insufficient funding for most practices; little disclosure in the media for the population and healthcare services; and few institutional spaces for their development in services[16].

On the other hand, in the international level there is increased demand observed in several countries: it is possible to state that the growing popularity of such practices is a worldwide reality[4,16]. The WHO has recently published the document *WHO traditional medicine strategy 2014-2023*, which demonstrated the substantial growth in ICP usage in the last decade. They estimate that more than 100 million Europeans, and an even higher number of people from Africa, Asia, Australia and the United States, are ICP users[4].

The reasons for such growth include several factors: increased demand caused by chronic diseases; high costs of health services, leading to demand for other forms of care; dissatisfaction with existing health services and conventional medicine; resurgence of interest in holistic and preventive care for diseases; treatments that offer quality of life when cure is not possible; empowerment of the user in their health-disease-care process; and switching to a wellness-centered health model of the individual and collectivities[4,22-24].

Among the CHAs participating in this research, the results showed higher ICP usage for those who presented negative self-perception of health. Professionals who evaluate their own health negatively can have ICPs as an effective alternative for promoting self-care and well-being. Therefore, the self-perception of health must be considered a useful tool, with consequent application in health promotion actions of the CHAs[25-27].

In this study, it was possible to observe that the use of homeopathy was associated to having higher education, whereas chiropractic care was significantly more practiced by CHAs with higher income. A previous study also verified the association between higher education levels and increased use of homeopathy[2]. The costs of homeopathy and chiropractic care in Brazil and the fact that the public health system still does not offer these practices widely may limit their usage. Hence, they are practices generally restricted to a small portion of the population that has the necessary financial resources to pay for the treatment[2]. It is noteworthy that better education and income levels can promote greater understanding on issues related to health and self-care, which can provide greater use of and access to ICPs. Extending such access could increase the use of practices with higher costs[16,23].

Association between higher frequency of relaxation/meditation and religion was also observed. The relationship between religiosity and health-disease-care process assumes considerable importance in this context, especially in the scenario presented in this study, where most people practice any religion. Relaxation and meditation are of low cost and can be an option for those who do not have access to integrative practices of higher cost[16].

In turn, seeking religious support can be explained, because having a religion comes from an institutionalized, historically and culturally accepted practice in Brazil, and may even be an important therapeutic resource. People seek for greater support in religion when they find themselves in situations of stress[23,27], a very frequent situation in the daily life of CHAs[27]. Thus, for these CHAs, religion can represent emotional and social support, originated from the relationship with people with whom one shares concerns, anxieties and hopes in order to acquire feelings of security, comfort and confidence[15].

Given the reality found in this investigation, it is worth mentioning that ICPs can contribute for seeking improvements in health care: knowledge and incorporating other knowledge and practices contribute to the construction of integral care. Actions that promote the use and insertion of ICPs in public health services, especially those of the PHC, are essential. The creation of discussion spaces on ways to include these practices in the routine of these services are also relevant in order to seek opportunities in the production of care and the approximation of health policies towards the population (22). For such, CHAs can contribute substantially, especially with regard to the dissemination of information about ICPs amongst PHC users.

Study limitations

Although this study has a pioneering character, it must be considered that its results have certain limitations. The cross-sectional design makes it impossible to define a relationship of causality for the associations identified. The sample, although representative, was restricted to professionals from a single municipality. Also noteworthy is that the variables were measured by self-report and, although this is a valid procedure used in several studies, it has the limitation of memory. It is worth mentioning that adjusted data analysys of use of ICPs was not performed in this research.

Contributions to the fields of nursing, health, or public policy

This study confirmed the need for ICPs to be properly recognized as effective ways of care, as they require a holistic perspective on the health-disease process and integrality of user assistance in the health system. In this sense, it is expected that this research adds new knowledge regarding the implementation of PNPIC for the Brazilian population and can contribute to the inclusion of these practices as health promotion strategies of the CHA.

CONCLUSION

The study demonstrated the use of ICPs by CHAs as forms of self care, with particularly high use of medicinal plants. The wide frequency in use of medicinal plants is explainable, since it is a practice with cultural roots in the population and that, therefore, must be recognized as having an important resource for health care. However, it is necessary to boost the use of ICPs and their insertion in SUS.

Furthermore, it is important to note that sociodemographic and health factors were associated with the practice of homeopathy, chiropractic care, massage, relaxation/meditation and integrative practices in general. The associations observed require attention, since they demonstrated that increased use of homeopathy and chiropractic care is limited to those individuals with higher education and income. The negative self-perception of health was associated with ICP usage, signaling that the CHAs possibly seek integrative practices as a form of dealing best with their well-being.

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