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Integrative and complementary practices: perceptions of Chi Kung practitioners

Práticas integrativas e complementares: percepções de praticantes de Chi Kung

PPrácticas integradoras y complementarias: percepciones de los practicantes de Chi Kung

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Natália de Toledo Cadore[1]
Felipe Menezes Ribeiro Galdiano[2]
Luiza Maria de Assunção[3]
Ailton de Souza Aragão[4]
Rosimár Alves Querino[5]

This is a qualitative and descriptive research carried out in a municipality in the state of Minas Gerais, Brazil, in the first half of 2016. This study aimed to understand the condition and perception of health, as well as the corporeality after the practice of Chi Kung in users of a specialized rehabilitation unit. Individual interviews and focus groups were used in an audio recorded way. Nine users participated, most of which were female, aged 19 to 59 years old, declared themselves *pardo* (mixed raced), in a stable relationship and with incomplete elementary education. In the content analysis, two categories emerged: *Walking through the SUS network*; and *Perceptions of health and corporeality*. Adherence to Chi Kung was related to: improvements in health conditions; previous care and bonding experiences with the professional. The development of self-care, de-medicalization and the expansion of perceptions of health and corporeality were highlighted as contributions of practice. The possibility of setting up groups in primary care was recognized by the participants. The institutionalization of integrative and complementary practices in the municipality is fundamental for the expansion of initiatives and access.
Descriptors: Complementary therapies; Qigong; Self care.

Esta é uma pesquisa qualitativa e descritiva realizada em um município mineiro no primeiro semestre de 2016, com o objetivo de compreender a condição e percepção de saúde, bem como a corporeidade após a prática de Chi Kung em usuários de unidade especializada em reabilitação. Utilizou-se entrevista individual e grupo focal de forma audiogravada. Participaram nove usuários, das quais, a maioria era do sexo feminino, na faixa etária de 19 a 59 anos, se autodeclarou parda, em união estável e com ensino fundamental incompleto. Na análise de conteúdo emergiram duas categorias: *Caminhar na rede SUS;* e, *Percepções de saúde e corporeidade*. A adesão ao Chi Kung relacionou-se a: melhorias na condição de saúde; experiências anteriores de cuidado e vínculo com a profissional. O desenvolvimento do autocuidado, a desmedicalização e a ampliação das percepções de saúde e corporeidade foram destacados como contribuições da prática. A possibilidade de implantação dos grupos na atenção primária foi reconhecida pelos participantes. A institucionalização das práticas integrativas e complementares no município é fundamental para a expansão das iniciativas e do acesso.
Descritores: Terapias complementares; Qigong; Autocuidado.

Esta es una encuesta cualitativa y descriptiva realizada en una ciudad de Minas Gerais, Brasil, en el primer semestre de 2016, con el objetivo de comprender la condición y la percepción de la salud, así como la corporeidad después de la práctica del Chi Kung en los usuarios de una unidad especializada en rehabilitación. Se utilizó la entrevista individual y el grupo focal con grabación de audio. Participaron nueve usuarios, la mayoría de los cuales eran mujeres, de 19 a 59 años, que se declararon pardas, en pareja de hecho y con educación primaria incompleta. En el análisis del contenido surgieron dos categorías: *Caminando en la red del SUS;* y, *Percepciones de salud y corporeidad.* La adhesión al Chi Kung estuvo relacionada con: mejoras en la condición de salud; experiencias previas de cuidado y vínculo con el profesional. Se destacaron como contribuciones a esta práctica el desarrollo del autocuidado, la desmedicalización y la ampliación de las percepciones de la salud y la corporeidad. Los participantes reconocieron la posibilidad de poner en práctica los grupos en la atención primaria. La institucionalización de prácticas integradoras y complementarias en el municipio es fundamental para la expansión de las iniciativas y del acceso.
Descriptores: Terapias complementarias; Qigong; Autocuidado.

1. Psychologist, Uberaba, MG, Brazil. ORCID: 0000-0003-4299-1474 E-mail: nataliatcadore@hotmail.com
2. Physical therapist, Specialist in Acupuncture, Uberaba, MG, Brazil. ORCID: 0000-0002-6470-458X E-mail: casaguilauberaba@hotmail.com
3. Social scientist. Master and PhD in Sociology. Professora of the Law course for the Universidade do Estado de Minas Gerais (UEMG), Ituiutaba, MG, Brazil. ORCID: 0000-0001-6106-1200 E-mail: luassunc@gmail.com
4. Social scientist. Master in Sociology. PhD in Nursing and Public Health. Post Doctor in Sciences. Adjunct Professor for the Collective Health Department in the Universidade Federal do Triângulo Mineiro (UFTM), Uberaba, MG, Brazil. Professor for the Graduation program in Environmental Health and Workers' Health (*Programa da Pós-Graduação em Saúde Ambiental e Saúde do Trabalhador - PPGAT*) for the Instituto de Geografia da Universidade Federal de Uberlândia (UFU), Uberlândia, MG, Brazil. ORCID:0000-0002-0793-2594. E-mail: ailton.aragao@uftm.edu.br
5. Social scientist. Master and PhD in Sociology. Associate Professora at the Collective Health Department for the UFTM, Uberaba, MG, Brazil. Professor at PPGAT/UFU/, Uberlândia, MG, Brazil. ORCID: 0000-0002-7863-1211 E-mail: rosimar.querino@uftm.edu.br

INTRODUCTION

Disenchantment with the biomedical model or with conventional medicine leads many people to seek alternative forms of treatment, so that the number of professionals who practice other models of care and cure is expanding. This search can be explained by the health and medical crises, and indicate gaps in the collective health systems and conventional therapies in meeting the totality of the population's health demands[1].

The search for alternative practices intensified in the 1960s, and was motivated by several factors, such as the change in the profile of diseases that affected the population; the increase in life expectancy and, mainly, a movement that initiated criticism in relation to the asymmetry of power between doctors and patients, which also consisted of thinking about new forms of relationship between these two places of care[2].

The proposal of integrative medicine brings to the fore an attempt to embrace different fields, from the interaction of alternative and complementary medicine with conventional medicine; the combination of ancient healing systems with modern biomedicine; valuing the relationship and professional-user communication; the consideration of the person in an integral way; the use of evidence; and the focus on health, cure and disease prevention[2].

These integrative practices seek transformations in the representations of health, illness, treatment and cure, characteristics that are very ingrained in today's society. The result of this search is the creation of new views that value the person and their relationship with the therapist as a fundamental element of health care, as well as the use of light technology[3]. This perspective also values health as a fundamental element of therapy, as opposed to the central role that the notion of disease and its combat occupy in the biomedical model. Thus, the new representations that emerge in culture from alternative therapies can be understood as a rescue of abandoned values in the therapeutic dimension of biomedicine[1].

According to the World Health Organization (WHO)[4], the term Traditional Medicines encompasses practices originating in the culture of each country, such as, for example, traditional Chinese medicine, Hindu Ayurveda and indigenous medicine. Thus, Alternative and Complementary/Traditional Medicines include manual and spiritual practices, with herbs, animal parts and minerals, without the use of chemically purified drugs (acupuncture, reiki, flowers, chiropractic), bodily activities (Tai Chi Chuan, Yoga, Lian Gong) and, referring to a branch of Traditional Chinese Medicine, which aims at mobilizing the subtle energy of the body, correcting disharmony and restoring the balance of the practitioner's physical and emotional health, among others.

In Brazil, since the creation of the National Policy for Integrative and Complementary Practices (PNPIC)[5] in the *Sistema Único de Saúde - SUS* (Unified Health System), in 2006, the term most used to designate complex medical systems and differentiated therapeutic resources is Integrative and Complementary Practices (ICPs).

PNPIC involves approaches that seek to stimulate the natural mechanisms for preventing injuries and recovering health, with an emphasis on welcoming listening, development of therapeutic bond and integration of human beings with the environment and society. Other aspects shared in this field are the expanded view of the health-disease process and the global promotion of human care, especially self-care, which brings them closer to health promotion. PNPIC considers, in its scope, the practices of Traditional Chinese Medicine (especially Acupuncture), Homeopathic Medicine, Medicinal Plants (Phytotherapy), Social Thermalism (Crenotherapy) and Anthroposophical Medicine[5].

The PNPIC aims to incorporate and implement ICPs in SUS, in the perspective of disease prevention, health promotion and recovery; expand the resolution of the health system and expand access, guaranteeing quality, effectiveness, efficiency and safety in use; promote the rationalization of health actions and encourage innovative and socially contributing alternatives to the sustainable development of communities; instigate actions related to control and social participation; promote the involvement of users, managers and workers, in the

different instances of the implementation of health policies[5].

Although the Ministry of Health has, since PNPIC, expanded the list of integrative and complementary practices[6], a study[7] indicates that there is no institutionalization of ICPs in most Brazilian municipalities. The lack of institutionalization has other consequences: instability and fragility in the provision of practices, challenges to ensure monitoring and evaluation and to ensure quality and safety for users.

It is noted the importance of studies on the process of incorporating integrative and complementary practices in SUS that can contribute to the understanding of the advances and challenges for their implementation and for the population, professionals and health institutions to overcome the medical and hospital-centered culture of health care[8].

The WHO highlights as one of the strategic elements of the Action Plan (2014-2023)[9] the establishment of channels for listening to users that allow them to understand the way in which they have experienced such practices, especially about who practices them, when and why they seek ICPs, benefits obtained and the qualification of the professionals who conduct them[9]. Extending studies can cooperate to guarantee the supply of ICPs with quality, efficiency and safety for users.

Chi Kung (CK) practice comprises a wide range of body exercise techniques. Their movements and postures are performed in a coordinated manner with psychic issues, mainly relaxation and breathing. The CK also includes massage and meditation. Flexibility and strengthening of the body are considered ways to achieve harmonic circulation of energy and the use of breathing is essential, as it is an important element to achieve the purposes set out in these practices[10].

Thus, this study aims to understand the condition and perception of health, as well as the corporeality after the practice of Chi Kung for users of a unit specialized in rehabilitation.

METHOD

This is a descriptive and qualitative study, which seeks to understand the internal sense or logic that the subjects attribute to actions, representations, feelings, opinions and beliefs[11].

The research scenario was a unit specialized in rehabilitation (USR) in a city in the interior of the state of Minas Gerais. The institution maintained by the municipal government serves exclusively through SUS. At the time of the research, the unit's technical team was composed of ten physical therapists, two psychologists and an occupational therapist. Among the services offered, physiotherapy, kinesiotherapy, psychotherapy, occupational therapy, acupuncture, Reiki and CK groups stood out.

The research was developed with users of three groups of CK of the USR. These took place twice a week, on alternate days and shifts, and were conducted by a physical therapist with specialization in CK and other integrative practices.

At first, the researchers participated in group meetings and presented the research. Subsequently, CK practitioners who met the following inclusion criteria were invited: participant in the CK group as part of their treatment at the institution for at least three months, aged 18 or over, regardless of gender, education and health needs met.

The exclusion criteria consisted of: not being able to travel to the place where the focus group (FG) takes place and having health commitments that do not allow communication with researchers and other CK practitioners.

In the period of data construction, from April to May of 2016, the three CK groups served about 25 users. Considering the recommendations for conducting focus groups[12].

The FG was conducted using a script with guiding questions that explored the motivations for the practice of CK, use of other health services in the SUS network and contributions from the integrative and complementary practice for your health. There was the participation of a moderator and an observer who noted the interactions between the participants.

The FG occurred in a room with conditions of secrecy and privacy, and were recorded and

transcribed in full. Content analysis in its thematic modality guided the organization and analysis of data[11]. In the analytical process, each member of the team developed a floating reading of the material produced in the FG with mapping of the units of meaning.

The categories were delineated as a team with a review of the convergences and possible divergences, with subsequent collective reading. The results were interpreted in the light of academic production on ICPs.

The research was approved by the Research Ethics Committee (CAAE nº 51105915.7.0000.5154). In this article, names of Brazilian musicians were assigned to identify the participants and ensure secrecy and privacy.

RESULTS

Profile of Chi Kung practitioners

Nine users involved in CK activities participated. Table 1 shows the characterization in relation to gender, age group, education and religion. The majority of participants were female (77.8%), aged 19 to 59 years (77.8%), self-declared to be *pardo* (44.5%), in a stable relationship (44.5%) and with incomplete elementary education (66.7%). Regarding religion, there was a diversity of creeds (Table 1).

Table 1. Socio-demographic profile of the participants. Minas Gerais, 2016.

Variable	No.	%
Gender		
Female	7	77.8%
Male	2	22.2%
Age groups		
Between 19 and 59 years of age	7	77.8%
60 years of age or more	2	22.2%
Ethnicity		
White	3	33.3%
Black	1	11.1%
Pardo	4	44.5%
Asian	1	11.1%
Marital status		
Single	3	33.3%
Civil union	4	44.5%
Divorced/separated	1	11.1%
Widowed	1	11.1%
Religion		
Catholic	3	33.3%
Kardecist Spiritist	3	33.3%
Evangelical	3	33.3%
Educational level		
Incomplete middle school	6	66.7%
Incomplete high school	1	11.1%
Complete high school	2	22.2%

Two thematic categories were built: *Walking through the SUS Network*; and *Perceptions of health and corporeality*.

Walking through the SUS Network

Users were asked about which health institutions in the SUS Network they used to care for their health. Municipal ambulatories were used (100%); Basic Health Units (BHU) and Family Health Teams (66.7%); Emergency Care Units (ECU) (55.6%) and outpatient clinics and university hospitals (33.3%).

As for referral for treatment at the USR, some points of the Network were mentioned, such as: ECU, municipal ambulatories and ambulatories linked to educational institutions. As for the body extension involved, it was found: lower limbs (44.5%), lower limbs and spine (22.2%),

general body pain/fibromyalgia (22.2%) and upper limbs (11%) .

In FG the users bring motivating complaints:

Mine was also due to a broken kneecap. I was playing sports, I was playing football. And I had already hurt my knee once, but not in the way it was now. Now the kneecap was broken, well, almost completely. (Nando)

Mine was inflammation in the elbow, then I went to the orthopedist [at the municipal outpatient clinic] *and he said to do physical therapy.* (Cassia)

I also came because I am undergoing treatment with the doctor [orthopedist] *and he referred me here.* (Rita)

What brought me here was the pain, which I felt a lot of pain in the body. I was directly at the ECU, complaining of pain in my back, legs, shoulder, neck. Then the staff told me to look for the doctor [at the municipal clinic] *and the doctor gave me the referral and I came here.* (Maysa)

When I arrived at the USR, I was a wreck, I was pretty wrecked [...]. *And I have follow-up at the* [federal teaching] *clinic, every 3 months.* (Elis)

With regard to the service time at the USR, 55.6% of the participants had been in service for up to six months; 22.2% from six months to one year and 22.2% for 13 months and more. And most participants had practiced CK for up to six months (66.7%); 22.2% had been practicing for 13 months and more, and 11.1% had been working for six to 12 months.

The referral to the EBU was focused on assistance by a physical therapist and, according to the participants, the doctors did not refer to CK or other complementary therapies as therapeutic possibilities. After joining the groups, some users informed doctors about the offer of CK in the URS:

She [the doctor] *asks how I am. Then I say that I'm continuing with physical therapy and the group. Then she told me to continue, that I should not stop, that it was being good for me, to keep going.* (Maysa)

I told him [the doctor] *about the techniques we used , but he didn't know the name, so he said "You see, what you're doing is for the whole body, you're not just doing it for the arm. You are already guaranteed, you are already doing complete care ".* (Cassia)

I arrived there [at the clinic] *practically dragged. I got there dragged, but not now. Now I go by myself. He* [the orthopedist] *was surprised, from the penultimate and the last time I went to see him. I went alone with no one accompanying me. He was startled the moment he saw me. Then he said: "Where are you doing physical therapy?"* [...] *He said to me: "I haven't had the opportunity yet to visit this place , but I've heard of it." Then I told him about physiotherapy, which is not physical therapy, it is Chinese physiotherapy.* (Elis)

Some of the participants shared other experiences in health services that, according to them, were centered on the use of devices and in which there was no commitment from the professionals. To make these criticisms, they compared the care received in private clinics and primary care with the work performed by the professional responsible for CK at the USR:

He [doctor] *said that in the center* [basic health unit] *they have a physical therapist, once a week* [professional from the Family Health Support Center]. *I got to go. I got there and they said they couldn't do anything for us, that what I need is a device. Do you see that if each center that had a physical therapist did what is done here* [Chi Kung group], [...] *if they were more interested, understand?* (Cassia)

But they [physical therapists] *have no interest in seeking, they do not provide me with anything* [...] *They have nothing, but they also do not go further, they do not seek.* (Carmen)

Where I did it privately, the physical therapist didn't even put my hand on it. She came close to me, wrapped that sign in the towel and tucked it under me, turned on the device, that thing was hot, the hour that passed the minutes went there and hung up. She never came near me, never lifted my leg, never took my heel, never tried to stretch my leg, never tried to do anything with me, understand? It was me alone. And I still paid for it. (Elis)

There was admiration for the professional who attends them at the USR:

I already told her: "You provide good care, you can keep a good conversation, you teach, you don't just prescribe." Because the good leader, goes ahead and shows you how to do it, and put their hand on you and show: "It is like this, like this and not just telling you to do it." [...] *it doesn't change, every day is the same thing, the same teaching, the same dedication, the same mood, do you understand?* (Nando)

But she is an excellent professional [...], *she loves what she does, it is not for everyone.* [...] *She does it with care, she gives attention to patients. There are few, to get the result that the physical therapist gets, don't you think?* (Renato)

The [professional] *helps a lot of people.* (Rita)

In addition to the admiration, the participants were attentive to details of the teachings of the CK practice and reported that this characteristic was also present in the professional, described as detailed and careful:

The [physical therapist] *is very delicate* [...] *In the beginning that I started doing with* [professional], *she helped me. She put her hand on my foot, lifted my leg, I was unable to get up.* (Elis)

She [physical therapist] *is very detailed, the good thing is this. That she does things and, at the same time, she shows:*

"Here you are doing, the time you get up and go away you will continue doing it." [...] *she teaches because she wants to see you well, this is very important.* (Nando)
So, she is determined, as long as she does not see that you are doing that exercise, that particular exercise correctly, she does not settle down. (Cassia)

Perceptions of health and corporeality

Users reported changes in their body conditions and, based on them, a reduction in their complaints. Reports of pain prior to the current injury were also included in this care:
Before I got here, I wasn't walking well, today I'm feeling much better, I'm walking almost normally [...] *I didn't bend my leg, I swelled a lot. And with the realization of this treatment here, it has been very beneficial because it is returning to normal* [...]. (Rita)
Like, because of a motorcycle accident I had, I have a problem with my left lower back. So, it turns out that the exercises I'm practicing here are reducing these pains a lot, you know? And I came because of a knee and I'm treating something else [...]. (Nando)

In addition to significant relief of their pain, CK practitioners pointed out positive differences in their mental and psychic state, revealing improvements in self-esteem and security in their own body on a daily basis. These perceptions signal the global impacts of the practice and dialogue with traditional Chinese medicine in which body, mind and soul are interconnected:
Psychologically, physically, people's self-esteem, everything changed. It [CK] *makes us calmer, I, for example, when I come here I get calmer, I sleep well, I get more relaxed, understand? Both physically and mentally. It covers more, mentally in people. You know? He gets more rest when you do this exercise.* (Elis)

This integral view was expressed at different moments of the FG. The participants noticed changes in their body shapes and postures after the start of the CK, especially in breathing, in the way they walk, the way they sit, stand and even sleep:
The way we sat, maybe your back hurt every time you had to keep moving to see if it would stop hurting. The way the professional has been teaching us, how to sit, how to walk. In addition to working there, you learn to pay attention to the exercise you are doing. So, it ends up making you work harder on how to do things right. [...] *Outside, we can also use, like the hip fitting, breathing, that's a lot to learn. You learning to breathe, learning to walk* [...]. (Nando)
I learned to see the way I sleep. I would get up anyway. I learned that you can't, first you have to throw your legs down, then you can lift from the waist up, I would get up anyway ... I had no posture. (Elis)

From this point of view where participants begin to look at their own health, there is a new sense that was previously unnoticed by them, that of self-knowledge and health education, as they begin to participate actively in their self-care.

In addition to promoting self-care, pain relief and better emotional condition are pointed out by users as a possibility of reducing the medications used:
Lately I don't even need medication anymore, I even stopped taking all the medications. Before I came here I was taking anti-inflammatory drugs and pain medication, after I started doing it I don't take any of that anymore, the pain ended. (Renato)
The amount of medicine we take, you can talk to everyone, has already decreased too much. The medications speak for themselves. (Cassia)

In the users' perception, the biggest motivation for joining the CK groups is related to the possibility that this practice allows its members to perform a complex activity in which the whole body is mobilized:
For pain not to come back. For you to see, my problem was in my arm, but it helped me in other parts of the body, so it's not just ... (Cássia)
I had back pain, but that changed, understand? A lot of pain in the calf and I don't have anymore. Understand? So, it started with the arm and improved other things. And other things that have improved are what motivate you not to stop ... (Carmen)

In addition, dimensions other than just the physical one are covered. It is possible to notice this articulation of different dimensions of human life when the interviewees claim to benefit psychologically from the practice of CK:
Not only the part affected by pain, you know, but you're reintegrating the whole body, you're rehabilitating the whole body [...] *you end up working from head to toe* [...] *You end up putting the whole body in an act so, of course you don't feel pain, you start to work better, sleep better, you wake up more excited in everyday life* [...] *And mentally. Mentally it seems like you do, because the pain ends up affecting you, right? The nervousness, the bad mood.* (Nando)
Psychologically, physically, people's self-esteem, everything changed. Psychologically, physically, mentally, everything.

All. (Elis)

The various forms of motivation that appear in the participants' reports are directly linked to the perceptions of their "new body" and its possibilities, especially due to the energy generated with the CK:

You have more spirit to work, to do, to talk. And more physical aptitude to do things. It gives a lot of energy, an energy that we do not have just with normal physical therapy, but you end up bringing it here, you see that you do the exercise you spend the energy, but at the same time, you leave here you leave much better. That same energy, you lose an energy, but you gain a positive energy, that you take it into your day. (Nando)

The narratives in the FG showed that the benefits perceived by users, stimulate them to join the group. In addition to the pain and injuries that motivated the search for the USR, practitioners referred to the development of preventive attitudes:

It is where I said that what we are learning inside here we can avoid, [...] *we can prolong a better life.* [...] *If it happens to get hurt it may be that it can happen better* [...] *in a smaller way or not at all, because of a good posture that we are learning here.* (Nando)

I'm not going to have a problem [...] *So, we are doing it today, you are already advancing things that could come ahead, you are already preventing for now* [...] *if I had learned this before, I could not having that.* (Renato)

Learning a healthier form of care unfolds in the socialization of knowledge with family members:

I teach my husband that he has to get up like that, I teach my father too. (Rita)

My daughter is very tall. I taught her to put the bucket on the chair to iron the cloth, for her squeegee we bought a PVC pipe [to put on the handle] *and make it a little bigger.* (Cassia)

DISCUSSION

The study scenario is a unit specialized in rehabilitation, which integrates the secondary level of health care. One of the characteristics common to participants is that they have been seen at other points in the network and are referred to the institution as a result of demands for rehabilitation. The referral was directed to rehabilitation centered on assistance by physical therapists.

Participants did not refer doctors' indications to use acupuncture or CK. Such fact may be related to the lack of knowledge of the services offered in the SUS Network at the municipal level and, also, to the resistance of professionals from different points of the network to incorporate the ICPs, as was observed in a study developed in another municipality in Minas Gerais[13]. It is also worth considering that training to work in ICPs is one of the main challenges highlighted by WHO[9]. It is imperative for the State to invest in the provision of training opportunities in ICPs to guarantee its expansion.

Some CK practitioners reported that, in the face of improvements in their health, they were asked by doctors about assistance in rehabilitation and clarified about body practices. The medical recommendation for continuity in the group in the face of the observed improvement indicates the complementary character that the practices assumed in the health care of the participants and reiterate the power of medical discourse in the care processes.

USR users, as well as professionals from different points in the network, were unaware of the existence of CK groups and only had access to practices when invited and clarified by the physical therapist. The case at hand is quite specific, as it is the only existing initiative in the SUS network in the municipality of Minas Gerais. Thus, it is understood that disseminating the experience can contribute to the implementation of new practices and encourage the discussion of PNPIC by managers, health counselors and the community in general.

The role of the physical therapist in the creation and maintenance of CK groups is also pointed out in other studies[7,14], as an important element to assess the institutionalization of practices. When initiatives take place through the efforts of professionals without the proper support from managers, the possibility of interruption and discontinuity of the offer is verified, as there is no state policy, but "people"[7]. The interest and investment of professionals to introduce new care practices can be genuine and confronted with the so-called institutional inertia[14].

When preparing the project for the present research, the USR maintained groups of Lian Gong, suspended due to the dismissal of the responsible physical therapist. This fact exposes the challenges to maintaining practices and reaffirms the importance of institutionalization, as already explained in experiences such as those in the cities of São Paulo[15] and Amparo[8], both in the state of São Paulo.

Research carried out with coordinators of primary care units in municipalities in the region of Campinas, also in the state of São Paulo, points to other developments of the lack of incorporation of ICPs as part of the teams' work process: work overload for those responsible for the ICPs; conflicts with team activities and lack of priority for ICPs in the face of various actions by the institution, in addition to conflicts of low recognition and visibility in internal relations[14].

Still regarding the attention users received in health institutions, in some reports it is possible to perceive criticisms of the hegemonic care model present even in the BUH and FHS in the city. Participants reported little "commitment" by professionals to solving their health needs, considered to be specific to specialized care and dependent on technology.

They envisioned the possibility of performing CK in primary health care (PHC), which is why they criticized the position of professionals from the Family Health Support Center (FHSC) that, without equipment, it would not be possible to "do anything"; and of the professional of the private health clinic, whose service was restricted to equipment, "without touching" the user. In other words: the participants captured the essence of light technologies[3] and the potential of care in the territories, as described in the literature[15].

The participants' understanding is in line with both the PNPIC[5] and the guidelines of the World Health Organization (WHO)[9] on the strategic place of PHC in the provision of ICPS. Studies[7,16] have pointed out the synergy between PNPIC and the Política Nacional de Atenção Básica - PNAB (National Primary Care Policy) and the reach of ICPs in the territories. The increase in practices in PHC has been a characteristic of national experiences, as indicated by research[7] in which it was observed that 74.35% of the supply of ICPs occurred in PHC. So that:

> "*Inserting ICPs in PHC is to recognize the therapeutic pluralism necessary in the complex daily management of health units, which requires a family and community approach, developing longitudinality of care and comprehensive care, converging premises of PHC and ICPS.*"[7].

The user in contact with the ICPs (re)builds the hegemonic representations of health, disease, treatment and cure. It creates other views that frequently value the subject and their relationship with the therapist as a fundamental element of the health-disease-care process, as well as the use of light technologies[1]. The quality that exists in the therapist-patient relationship is a central aspect for ICPs. This must be one of care and attention to the various developments that may be linked to a person and their pain, or to their illness.

In a broader way, the participants described the construction of therapeutic relationships based on listening, building bonds and learning. CK practitioners point out crucial themes that touch on the institutionalization of ICPs in SUS and that imply the training of professionals and the construction of a new culture of health care based on comprehensiveness[7].

The data presented here are in line with the findings of another investigation[17] in relation to the provision of ICPS in specialized services. The comprehensive approach to users' demands influences care in individual modalities and also in body practices[17]. The study participants used physical therapy, acupuncture and were CK practitioners. The uniqueness of the scenario of this study lies in the fact that the offer of ICPS occurs in a rehabilitation service whose actions are centered on conventional medicine. Thus, it is possible that access to acupuncture and subsequent adherence to CK body practices have been influenced by the link with the physiotherapist who attended and endured even after achieving conventional treatment.

Among the bodily practices contained in the PNPIC, CK is a therapeutic practice that can be understood, learned and performed by people with relative ease, despite its complexity,

breaking with the passivity of Western health treatments and with restricted access to preventive practices. and integrative[8,18].

The CK has a therapeutic and preventive action that is easy to assimilate, which can be practiced autonomously by individuals, allowing the addition of autotherapy to the care of specialists, which enhances the effectiveness of prevention and treatment, reducing recurrences. The varied combination of resources depends on the needs of each individual[18].

There were benefits from the practice of CK provided in their lives, both in the physical and psychic dimensions. It brought more security in relation to the body itself regarding basic postures in everyday life and attitudes related to self-confidence and self-esteem. Users of body practices in PHC in the city of São Paulo reported improvements in mobility, memory, management of chronic diseases, balance, depression and anxiety[15].

The regular practice of this form of Chinese gymnastics, both in old age and in people with some type of physical limitation, allows adequate movement to release muscles, ligaments, tendons, improving and expanding the range of movement of the joints and, with that, the decreased pain[18].

Ensuring psychological well-being and improving sleep quality are results commonly found with CK in at least one month of practice. In addition to increasing the sense of control, it promotes self-discovery and a sense of well-being in practitioners, developing more flexibility and adaptability in their thoughts, emotions and behaviors. In addition; improves the process of mental self-regulation; preventing disorders of this nature; decreasing stress, uncertainties, anxiety and depression[18].

With the use of CK, it was possible to notice the decrease in the use of medications, which is an important data when considering the valuation of these forms of care within SUS[19]. A study developed with elderly Lian Gong practitioners also pointed out the reduction in the use of medications, incorporation of a positive perception of health, autonomy in self-care actions and reduction of impediments to activities of daily living[20].

The topic of de-medicalization of health and the incorporation of new forms of care has historically been limited to academia. With the ICP, especially the CK, there is a unique possibility of putting a differentiated alternative focus on acting in rehabilitation and expanding the possibilities of health promotion. Such an undertaking is characterized as an effort in the search for valorization and propagation of practices that contemplate the totality of the human being and the integrality of care.

Many physical problems derive - or at least worsen - from mental or emotional stress, so the inner tranquility provided by CK cannot be underestimated[18]. This practice helps to manage stress, anger, among other feelings that can affect the subjects' daily lives and minds.

Self-care is understood as a fundamental element for new health practices due to the possibility of developing personal skills and empowering subjects[21]. Health promotion is a field of proposals, ideas and practices that is growing in public health, strives for a broad conception of the health-disease process and its determinants and proposes the articulation of technical and popular knowledge, as well as the mobilization of institutional and community, public and private resources to face and resolve them[22].

ICPs have elements that may converge with the principles of health promotion and, as such, prove to be de-medicalized. It can be seen that this is an extremely important issue for ICPs: the insertion of practices that enhance the autonomy of individuals; awareness of the health-disease process, making individuals become part of this process[20]. It is also worth highlighting the relevance of the multidisciplinary team, the decentralization of treatment, which should not be linked exclusively to the figure of the doctor[8,15].

In group interactions and bonds, the subjects are interconnected in order to produce specific formations and psychic processes[23]. Despite being individual, these new formations will be shared globally among them, that is, even if each subject building new ideas and perceptions about themselves and about the activities practiced, these will be elaborated by all

the participants present, being, therefore, considered a construction group.

In addition to thinking about these new constructions, shared feelings are also taken into account when the issue of groupality is brought up. The moment the participants enter the group, they are suffering from their own pains and difficulties and, from that meeting, they can identify subjects with similar issues and then share the anxieties they previously kept only for themselves[23].

Being in a service where there is the participation of other people with physical difficulties and similar pain, in addition to bringing a sense of empathy and recognition, is beneficial for professionals to welcome more patients who need this care. Due to the integrative and collective character of the practice of CK in the URS, it is noted that it also helped to lift people out of isolation, facilitating the reestablishment and/or expansion of communication and interaction, helping in the formation of support networks.

Body practices such as CK find in PHC special potential to expand the circulation of users through territories, foster intersectorality[15] and horizontal relationships between workers and users, guided by dialogicity and articulation of knowledge[24].

CONCLUSÃO

The research enabled the contact and better knowledge of the practice of CK and provided the apprehension of its value as a way of care and comprehensive health care. This fact was evident through the positive reports that, at the same time that they exposed the resoluteness of the practice, justified the motivation for adherence and continuity of the care process provided by the CK.

It was possible to access the perceptions of SUS users of this integrative and complementary practice and understand how the CK contributed to the (re)construction of their perceptions of body, health and care. Changes in their bodily conditions were established and, from them, the complaints that previously appeared in a marked way give way to other attitudes and care for themselves. The emphasis is on greater intimacy with themselves, in the sense of empowerment in relation to their own bodies, leaving them to occupy a passive place in resolving issues related to health and quality of life.

The limits of the study refer to the singularities of the analyzed scenario, which makes generalizations unfeasible. However, the importance of emphasizing how users have experienced ICPs and the perceived benefits, fundamental elements for the institutionalization of these practices and the guarantee of supply with effectiveness, quality, safety and respect for cultural practices, is advocated.

The dissemination of the CK experience in the USR can encourage other points in the SUS network, especially the PHC, to invest in other forms of care and health promotion. It is about sensitizing the community, workers and managers in the construction of local initiatives.

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CONTRIBUTIONS
Natália de Toledo Cadore, **Luiza Maria de Assunção** and **Rosimár Alves Querino** participated in the conception, data collection and analysis, writing and revision. **Felipe Menezes Ribeiro Galdiano** contributed with data collection and analysis, writing and revision. **Ailton de Souza Aragão** worked on the analysis, writing and revision.

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