Policy on Integrative Health Practices of Federal District in Brazil: Evaluability Study

Política de Práticas Integrativas em Saúde do DF-Brasil: Estudo de Avaliabilidade

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ABSTRACT Integrative and Complementary Practices in Health include different health care forms and have been present for more than decades in health services in the Federal District, where the implementation assessment of your policy is not completely defined. To assist in understanding reality, an Evaluability Study was carried out collaboratively, involving discussion with stakeholders, questionnaires and consultation of documents. The policy components were identified, organized and modeled. A simplified-logical-model and one of the operational-logical-models, validated by the participants, are presented in this article. For policy evaluation, the initial aspects of the modeled logical implementation chain were prioritized. It was identified as fundamental the promotion of the actors' knowledge about the set of resources to the implementation of the Integrative Practices services and about the related intersectoral responsibilities. Formative, qualitative and collaborative assessments are suggested. The modeling carried out in the studies of this policy, shed light on the study of similar ones.

KEYWORDS Health evaluation. Complementary therapies. Health policy. Public health. Health management.

RESUMO *As Práticas Integrativas e Complementares em Saúde incluem diversas formas de cuidado de saúde e estão presentes há mais de três décadas nos serviços de saúde no Distrito Federal, onde a avaliação de implantação da sua política não está completamente definida. Para auxiliar na compreensão da realidade, foi realizado Estudo de Avaliabilidade, de forma colaborativa, envolvendo discussão com stakeholders, questionários e consulta a documentos. Foram identificados, organizados e modelizados os componentes da política. Um Modelo-lógico simplificado e um dos modelos-lógico-operacionais, com conteúdo validado pelos participantes, são apresentados neste artigo. Para avaliação da política, foram priorizados aspectos iniciais da cadeia lógica de implementação modelizada. Identificou-se como fundamental o fomento ao conhecimento dos atores sobre o conjunto de recursos necessários para implementação de serviços de práticas integrativas e sobre as responsabilidades intersetoriais relacionadas. Sugerem-se avaliações formativas, qualitativas e colaborativas. A modelização realizada possibilita continuidade nos estudos desta política, lançando luz ao estudo de políticas semelhantes.*

PALAVRAS-CHAVE *Avaliação em saúde. Terapias complementares. Política de saúde. Saúde pública. Gestão em saúde.*

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Introduction

Traditional and Complementary Medicine (TCM) originate from various parts of the world and have their use recommended by the World Health Organization (WHO)[1]. In Brazil, they are called Integrative and Complementary Health Practices (Pics), a term that refers to complex medical systems and other therapeutic resources that contribute to the global promotion of human care, including the expansion of individuals' co-responsibility for health[2]. Since 2001, the Federal District (DF) has defined Integrative Health Practices (PIS) as the set of technologies that address human health in its multidimensionality, promoting its role as protagonist, co-responsibility, emancipation, freedom and ethical attitude, to promote, maintain and recover one's health[3].

The National Policy on Integrative and Complementary Practices (PNPIC) for the Unified Health System (SUS) in Brazil was published in 2006, guiding the implementation of these practices in the country and sharing responsibilities with state management, but without defining or standardizing its evaluation2. Partial national monitoring takes place through computerized systems[4], but municipalities are responsible for local monitoring of implementation and results[5].

In 2015, 527,953 individual consultations were registered in the Brazilian Primary Health Care information system in Pics, in 1,362 municipalities[6]. However, the growth and expansion of Pics in the country does not mean institutionalization and sustainability of the PNPIC, without which there is fragility and instability of supply and difficulty in monitoring and evaluation to contribute to safety and quality[7].

The multifactorial context of mismatches in the implementation of policies for integrative and complementary practices in health[7-12], added to the lack of definition of ideal mechanisms for evaluating these practices[4,13-16], makes studies necessary to better understand their operating logic and seek viable strategies for such evaluations.

The Evaluability Study (EA) has the potential to assist planning, contributing to the feasibility of proposed actions in the field of public health, helping to develop realistic objectives and to provide quick and low-cost feedback on implementation. It does not intend to generate evidence on effectiveness, but to identify the logic of the program, in addition to mismatches in the intervention[17].

The EA is of particular value to managers who wish to promote organizational learning, which can serve as an instrument to transfer a program to new leadership, and to anyone planning an evaluation[18]. Also, by generating understanding of the mechanisms through which the intervention achieves its results, it may indicate necessary adjustments in objectives, activities or resources, increasing its potential to meet the needs of society[17,19].

With more than three decades of history since the beginning of the institutionalization of these practices in public health in its territory, the DF can be considered a pioneer in Brazil[20]. In the last quadrennium of management, 80% of the Primary Care Managements in the DF offered PIS[21]. The District Policy for Integrative Health Practices (PDPIS) – as the object of this study – enabled the translation of a reality that can contribute to the states of the federation.

Due to its strong potential to contribute to the implementation of Pics policies, the EA presented in this article was carried out, with the objective of expressing the PDPIS operating logic and identifying aspects of its implementation for monitoring and evaluation. This publication follows the quality standard suggested by Baratieri et al.[22].

Materials and methods

The PDPIS[23] EA was carried out using a mixed research method, using document consultation, research meetings, a policy strategy spreadsheet and a questionnaire, following the steps described in *box 1*. *Box 1* presents the research strategies and resources used in each

evaluability stage, adapted from Wholey[19] and Leviton et al.[17]. Quali-quantitative data were used for modeling, through frequency analysis and consensus techniques.

Box 1. Research strategies used in the present study, in stages adapted from Wholey[19] and Leviton et al.[17]. Federal District, 2020

Stages	Aspect addressed	Research strategy	Main resources
Involving stakeholders in the assessment	What are the favorable and unfavorable stakeholders in the assessment whose perspective should be considered. What is the performance of each in relation to the PIS and how to approach it.	Validation of the Matrix of interested parties. Questionnaire validation.	1st Meeting with the GERPIS team. Matrix of interested parties. Questionnaire proposal.
Clarifying policy intent and beginning modeling	Engage stakeholders and determine the scope of the policy – objectives and guidelines. Logical relationship between PDPIS components.	Discussion with technical team. Construction of Logical Model. Collection and analysis of available information.	1st Meeting with the GERPIS team. Document verification. Questionnaires.
Exploring the Reality of Policy Enforcement	How is the implementation of PICS in the DF and the implementation of the policy under study – actions.	Discussion with technical team. Collection and analysis of available information. Construction of Logical Model.	1st Meeting with the GERPIS team. Activities worksheet. Document verification. Questionnaires.
Checking plausibility, validating and adjusting the design	The set of information obtained and organized in a logical way must be plausible and in accordance with the reality encountered.	Analysis, adjustment and validation of the elaborated policy logic-models.	2nd and 3rd Meeting with the GERPIS team. Available documents. Questionnaires. Logic-models.
Exploring possibilities for evaluation and monitoring	Interest and feasibility of monitoring or evaluation.	Summary presentation of the material. Discussion with technical team. Alignment between documents, opinion of different actors and policy-logic models.	2nd and 3rd Meeting with the GERPIS team. Available documents. Questionnaires. Logic-models.
Checking policy implementation priorities and development points	What aspects should be prioritized in the evaluation/monitoring. What are the other interests and needs in the use of the information obtained.	Summary presentation of the material. Discussion with technical team.	2nd and 3rd Meeting with the GERPIS team. Available documents. Questionnaires. Logic-models.

Source: Own elaboration.

Carrying out evaluability with policy stakeholders was a dynamic process, with information being aggregated, validated and adjusted throughout its development[17]. EA interactions allowed for adjustments in the logical design and evaluation intentions, based on the repeated use of research resources and the review of information obtained at each stage[17,19]. EA development took place between 2020 and 2021.

In the first stage of the research – focused on involving the interested parties – the context of the study was verified, consulting the available public documents. The DF has Brasília as its only municipality, with around three million inhabitants. The State Department of Health of the Federal District (SES-DF) has central and regionalized management, with no municipal health departments. Each of the seven Health Regions has a Superintendent as the

highest authority and it is up to the regional management to act on the implementation of the PIS policy, as well as other health policies. The network has an exclusive PIS basic unit and two Live Pharmacies.

The Management of Integrative Health Practices (GERPIS), central management unit of SES-DF, was responsible for creating and updating the PDPIS. During the study, it was the unit responsible for promoting its implantation and implementation in the SUS-DF, including related educational processes.

The PDPIS, published in 2014 after public consultation, appreciation and approval by the SES-DF Management Collegiate and by the DF Health Council, included: Acupuncture; Art therapy; Self massage; Phytotherapy and Medicinal plants; Hatha Yoga; Homeopathy; Lian Gong in 18 therapies; Anthroposophical Medicine and Therapies; Meditation; music therapy; Reiki; Shantala; Tai Chi Chuan; and Integrative Community Therapy. In 2019, the following were also included in the DF health network: Laya Yoga, Stress Reduction Technique®, Ayurveda[3,24]. In 2022, Auriculotherapy[25].

Each PIS had one or more public servants acting as District Technical Reference (RTD), linked to GERPIS, which contributed to the development of clinical management processes, with the qualification of PIS facilitators and with permanent education[26,27]. The health units had the figure of the PIS Facilitator, a qualified professional who organizes, supervises, informs, executes and monitors the implementation of the PIS individually or in groups[28].

In a meeting, the study and concepts used were presented to the GERPIS team. The research questionnaire was applied and validated, three participating Health Regions were randomly selected, information was obtained for selection and contact with other actors involved, and the groups of study participants were intentionally defined, based on the main people involved in the implementation of this policy[29].

Care professionals and central and regional managers of the SES-DF participated in the study, in addition to members of the Health Council of the DF. The selection criteria included professional work with PIS and Managements with the highest number of PIS implemented, prioritizing representativeness of the different PIS and seniority in the SES-DF (*box 2*).

Box 2. Number of participants, selection criteria and forms of participation in the Evaluability Study, DF, June 2021

Participants	Expected No.	Effective No.	Selection criteria and strategy	Form of participation
Central technical group: members of GERPIS	10	13	Professionals who work at GERPIS, assigned or not.	Face-to-face discussion and consensus meetings; provision of information and internal documents; and self-response in an electronic questionnaire, during a face-to-face meeting.
CSDF User Representatives	03	03	They will be invited into a CSDF meeting, based on their active participation during the meeting.	Assisted response to the questionnaire, in a virtual meeting.
District Secretary of Health	01	00	Holder of the position or person appointed by him.	Did not participate.
SAIS, COAPS, DAEAP	03	03	Holder of the position or person appointed by him.	Self-response in electronic questionnaire, assisted in person.
Superintendents	03	01	The superintendent of the 3 RA randomly chosen.	Self-response in electronic questionnaire.
DIRAPS	03	02	The director of the 3 RA randomly chosen	Self-response in electronic questionnaire

Box 2. Number of participants, selection criteria and forms of participation in the Evaluability Study, DF, June 2021

Participants	Expected No.	Effective No.	Selection criteria and strategy	Form of participation
GSAP managers	03	03	1 GSAP in each of the randomly selected ARs, selecting the one with the highest number of PIS implanted.	Self-response in electronic questionnaire.
APS professionals qualified in PIS	15	17	One civil servant trained in each PIS among those assigned to the participating GSAP, even if inactive in practice, with preference for older civil servants at the SES.	Self-response in electronic questionnaire.
TOTALS	41	42		

Source: Own elaboration.

User representatives on the DF Health Council were the only stakeholders external to SES-DF. Stakeholders exclusively linked to secondary or tertiary care were not consulted, as primary care has historically been emphasized in the implementation of PIS[1-3].

For the second stage of the research – clarifying the intention of the policy and starting the modelling – the GERPIS group provided documents from the sector. In a meeting, the objectives and guidelines of the PDPIS were identified and aligned, following the views of the participants. The other stakeholders involved answered the survey questionnaire.

Official monitoring reports of the 2016-2019 District Health Plan and regulations, which are publicly accessible, were consulted. Also GERPIS internal documents, from 2020, containing its work processes[30] and records of meetings for the preparation of a new text for the PDPIS.

In view of the third stage – exploring the reality of PDPIS execution –, in addition to the documents and questionnaires, GERPIS professionals expressed their views on each of the 72 PDPIS strategies. A spreadsheet was prepared for this purpose, containing: execution, feasibility, expected results, how to measure results, pertinence in the guideline to which they belong and in relation to the policy objectives, clarity, which operational axis they could be part of, among the proposed axes, activities developed and comments.

In the fourth stage of the research – checking plausibility and adjusting the design –, in light of Leviton[17], Thurston and Ramaliu[18], Wholey[19] and Rossi, Lipsey and Freeman[31], the elements were rearranged and some original texts of the policy were modified, in order to elaborate the first complete version of the models intervention logic.

This process was based on the detailed material obtained. No information was discarded, so the most frequent ones served as the basis for modeling. The consultation of documents and regulations confirmed and facilitated the organization of contributions from the group of people involved.

The responses obtained in the previous steps were organized in an Excel spreadsheet for frequency analysis. The only open question in the questionnaire ratified information obtained. The proposed operational axes were used for classifying and aligning the strategies, as some generated doubts when reading or were too complex.

Some policy strategies integrated the model guidelines, others remained as strategies, and most were shifted as actions in each strategy. Five actions carried out that were not included in the PDPIS text were included, and twelve strategies were discarded by consensus on their non-implementation.

The Simplified Logical Model (MlogS) explained the relationship between the fundamental elements of the PDPIS, while the Operational Logical Models (MlogAt), one for each policy strategy, explained the execution of activities related to its implementation identified during the study (*figures 1 and 2*).

The second and third meetings with the GERPIS group allowed for a deeper discussion on the models under construction, which were analyzed and validated by the group, after presenting the results of the questionnaires. There was a consensus suggestion for adjustments to better describe the reality of policy implementation.

Modeling was improved to increase emphasis on three aspects of policy implementation considered by the GERPIS group to be more relevant than represented in the proposed design: educational activities, community participation, and sharing information about PIS.

The fifth and sixth stages of the study – exploring possibilities – were initiated in the last meetings. Priorities and feasibility of monitoring and evaluating the PDPIS were discussed, based on the most frequent responses in the survey questionnaire and the logical models validated by the GERPIS group, as well as on the challenges for implementation and monitoring. All the prepared material was made available so that the participants of this group could register other answers or ideas, closing the stages of the research.

Under registration CAAE 35488720.3.0000.5240, this research project was approved by the Research Ethics Committees of the Sergio Arouca National School of Public Health and the Health Sciences Teaching and Research Foundation, in the Federal District.

Results

Of the total number of study participants, 38 answered the questionnaire, 25 (65.8%) of whom were female. The complete level of education of the majority was specialization (52.6%), followed by higher education (26.3%), master's (13.2%) and high school (7.9%). Restricting the analysis only to those who participated in the group of PIS facilitators, 52.9% had a postgraduate degree and 11.8% had no higher education.

The 10 years tenure of 77.1% of the 35 SES participants' and their diversified professional background help to understand the institutional reality. The three user representatives on the Health Council were participants outside the SES.

GERPIS was made up of administrative technicians, a manager, RTD holders and collaborators of the PIS modalities, a senior civil servant responsible for monitoring and a multiprofessional postgraduate resident. The lead author of this study was part of the team as RTD.

During the stakeholder consultation, there was a lack of clarity in some guidelines and strategies in the policy text, with repetition of ideas. The document referred to the context at the time of its preparation, requiring updates, and presented a structure with little connection between its components, with strategies that were not hierarchical, prioritized, or clearly related to objectives or results.

3 guidelines were outlined in the first modeling with the GERPIS group. Later, one on professional education in PIS was added. The final version of the proposed MlogS of the PDPIS (*figure 1*) presents four guidelines, which define the lines followed in the operationalization, each one with an objective and two strategies for the construction of action plans. This is the first known modeling of the PDPIS elaborated in 2014. In the dynamics of the model's operation, the products of the strategies are also feeding and feedback resources of the model and the desired results can exist if there is joint achievement of objectives.

Figure 1. Simplified logical-model of the PDPIS 2014, from the Evaluability Study of the policy. Federal District, 2021

Purpose of the PDPIS (major objective): to promote, using the PIS, a health culture, with autonomy and empowerment of people and communities for self-care, in the SUS-DF, increasing the satisfaction of health professionals and users, the rationalization of health actions and the resolvability of the system.

Resources	Guideline	Specific objectives	Strategies	Product/Resource	Results
	Strengthening the institutionalization of PIS in an intersectoral and transversal way, with community participation.	Regulate and manage the work with PIS of the set of sectors and actors of the SUS-DF, to meet the demands of the community.	Organization of PIS management, education and services throughout the SUS-DF network with institutionalized standards and technical information. Strengthening management for the implementation, monitoring and evaluation of PIS in SUS-DF.	Management, education, implementation and execution of PIS throughout the SUS-DF network,legitimized and instrumentalized by norms and technical information. A PIS public management that is cohesive, active and articulated intersectorally with the health network.	
	Professional education for safety and the quality of the PIS offer.	Educate professionals for the implementation and qualified use of PIS in SUS in the Federal District.	Professional education for strategic and timely inclusion of PIS in health services. Qualification of professionals to apply contemporary and traditional scientific knowledge of PIS.	Network managers with knowledge for strategic and timely inclusion of PIS services in the network. Professionals able to work with PIS, integrating scientific and traditional knowledge.	- Acting with PIS throughout the SUS-DF network standardized and managed to meet the needs of the community.
	Provision of PIS services at the three levels of health care.	Offer PIS services throughout the SUS network in the DF.	Obtaining adequate structure and conditions for the implementation of PIS. Networking to subsidize, expand and improve the offer of PIS services in the SUS-DF.	PIS services available in locations and with appropriate instruments. PDPIS executed in coordination with internal and external actors of SES-DF.	- PIS services performed in a safe and timely manner in each space of the SUS-DF health care network.
	Use of PIS as care technologies for maintaining, protecting and recovering health.	Ensure broad access to PIS knowledge and services available by SUS in the DF	Promotion of broad access to knowledge about PIS. Promotion of broad access to PIS services available by SUS in the DF.	Comprehensive care and health promotion technologies available to all through SUS-DF.	- PIS services and knowledge used for the promotion, protection and recovery of comprehensive health throughout the SUS-DF network.
Impact of PDPIS: Contribution of PIS to a culture of health, with autonomy and empowerment of people and communities for self-care, increased rationalization of health actions and system resolution, satisfaction of health professionals and users, in the SUS-DF.					

Source: Own elaboration.

The text of the PDPIS generically predicted the budget guarantee as a strategy for its institutionalization. Funding had been carried out by various sources, but nonspecific and with little definition, which is why MlogS does not make it explicit in the first guideline, translating it as an absent resource in the logic of the policy's operation, despite the trend of change in this scenario, which will require updates of the logic-model.

The word strategy came to represent the main sets of actions aimed at certain results, implying a reduction of the 72 in the text to only 08 strategies in the model. While the policy follows its purpose as a major objective, the strategies follow the specific objectives in each guideline. The design of the current functioning of each strategy, with the actions developed, even if partially, irregularly or in an initial phase, and their expected effects was represented in eight MlogAt, exemplified in *figure 2*.

Figure 2. Operational logical model of strategy 4 of the PDPIS 2014, from the Evaluability Study of the policy. Federal District, 2021

OBJECTIVE: Educar profissionais para implantação e uso qualificado de PIS no SUS do DF.			
STRATEGY 4: Qualification of professionals to apply contemporary and traditional scientific knowledge of PIS.			
Resources			
• People with technical, traditional, educational and PIS management knowledge, responsible for activities • Material, technological and human resources • Establishment of criteria for qualification in PIS • Political and management support and interest			
Activities	**Product**	**Results for each action**	**Measurement of results**
Regular offer of qualification courses for health workers in the SES-DF network.	Availability of qualification courses for institutional work with PIS at SES-DF.	Health professionals qualified to work institutionally with PIS. Providing care with PIS by health professionals uniformly qualified by the institution, according to its criteria and needs.	Number of public servants certified in the institution's parameters, active and inactive. Repressed demands for courses.
Conducting permanent education (PE) for workers who deal with PIS, based on a diagnosis of the network's needs.	Offer of a permanent education to the network's public servants to work with PIS in the institutional reality.	Professionals with up-to-date and appropriate knowledge to work with PIS in the institutional reality. Increased resolving capacity of professionals in PIS services. Sharing experiences and expanding self-management in service. Constant updating of knowledge and techniques by the instructors/facilitators. Easier implementation and maintenance of PIS services.	Ability to resolve cases by facilitators for implementation and maintenance of the PIS offer. Skill and technical security of facilitators in conducting PIS services. Updating of public servants in relation to institutional norms and technical guidelines for offering PIS on the network.
Carry out technical-scientific partnerships for training and permanent education.	PIS education projects carried out with partner sectors or institutions.	Expansion of education and work strategies with PIS. Increase in the quality of continuing education. Expansion of the number of beneficiaries with technical knowledge. Improvement of the PIS services of the SES-DF network with adherence to successful external trends in similar contexts.	Number of participants in the EP. Satisfaction of professionals with EP. Expansion of the PIS offer (number of appointments, units that offer and types of practices offered). Improved access to PIS. Improvement of work processes with implemented PIS.

Figure 2. Operational logical model of strategy 4 of the PDPIS 2014, from the Evaluability Study of the policy. Federal District, 2021

Support the participation of professionals working with PIS in technical-scientific events.	Participation of professionals working with PIS in scientific events, with central support.	Dissemination of internal scientific work at external events. Performance with PIS based on scientific knowledge. Valuing local surveys with PIS. Incentive to scientific production in the DF. Update of scientific knowledge for the internal network of SES-DF.	Number of technical or scientific events with PIS participation.
Strategic implementation of PIS courses for professionals from other agencies or public and philanthropic institutions.	Availability of PIS courses for public and philanthropic services outside SES-DF.	Professionals from the public or philanthropic sector qualified to work with PIS. Qualified use of PIS in public or philanthropic sectors outside the SES-DF.	Number of events, participants and PIS actions or services carried out in public or philanthropic services outside the SES-DF.

Source: Own elaboration.

The text of the policy only mentioned GERPIS for PIS management, care, teaching and research, without making explicit the responsibilities of other stakeholders, which weakens intersectoral actions inside and outside the SES-DF. However, growing movements of decentralization of management focused on PIS, such as standardization, action of supporters at the three levels of care and expansion of a basic unit exclusively for PIS, strengthen its implementation and monitoring.

The partnerships for the management or implementation of the PDPIS were also explicit, when 76% of the respondents in the different groups indicated the existence of, on average, 3.5 partnerships each, in their scope of action, mainly with schools or universities, community groups and other health units.

As for PIS services, they follow the same institutional norms used in the management of other health policies implemented in the DF. However, it did not seem clear to the participants of this study how the PIS were organized in terms of decentralization of management and responsibilities, in order to guarantee intersectoral commitment and the different resources needed to implement the PDPIS.

Regarding monitoring, the District Health Plans (PDS) included PIS offer indicators and the 2019 Annual Management Report indicated 100% achievement of the objective regarding the strengthening of PDPIS actions in the last quadrennium[21]. However, in the opinion of the GERPIS team, such indicators were limited to absolute numbers that do not translate or explore enough aspects of reality and the inadequacy of Pics codes in the SUS information systems leads to underreporting of services[32].

Despite the limitations, the team highlighted that the indicators played a fundamental role in mapping SES-DF Network services and allowing the planning of new services. By integrating the PDS, they contributed to discussions on priorities in health management and to the expansion of PIS information, from senior management to the community.

Following it has favored the recording of other important data for monitoring, on the facilitators, number of assistance, intersectoral and educational actions, among others, thus existing a partial qualitative monitoring. Current monitoring is consistent with the proposed MlogS guidelines, despite not sufficiently supervising the expected effects in each of them, as explained by the GERPIS group.

In assessing the evaluability, the plausibility of the program is central to determine its potential to be evaluated, since it indicates whether it is feasible to achieve the proposed objectives with the activities foreseen in the continuous causal chain of the logical model[17,33,34].

Stakeholders agreed, for the most part, on the main elements of the policy, which allowed modeling, linking them in a logical way. With the first four objectives of the PDPIS original text, 95% or more of the participants agreed totally or partially; with the fifth, 87%. No participant strongly disagreed. All declared themselves interested in implementing the PDPIS.

Another relevant data from the study was that 73.7% of the participants were at that time or had already been users of any of the PIS available by the SUS in the DF. This result corroborates the monitoring data, demonstrating implementation and access to PIS in the service network. The interest in implementing other PIS within its scope of action was registered by 73.6%, in a similar percentage for the different groups consulted, and the lack of interest may be linked, in the opinion of the GERPIS group, to the current implementation management limitations, such as operationalization of services, monitoring and technical follow-up.

Almost 80% of the participants stated that the community helps with the implementation, however 50% agreed totally or partially that there are professionals in their area or workplace who voluntarily make it difficult. Several participants worked in the same places, so this aspect needs to be further explored to be better understood.

The lack of support from managers was emphasized by participants in the questionnaires and meetings, with implications for the availability of resources and the functioning of services. Part of the participants reported never having been a PIS user or practitioner, which can be associated with a lack of knowledge, which is also a necessary resource for the implementation of the policy and can be a factor that hinders its implementation, increasing the importance of the policy.

The implementation of the PDPIS requires the availability of knowledge for the network, which, despite not being so explicit in the original text, not being uniform among the PIS modalities and not reaching all units, was part of the actions developed over the years, favoring the maintenance of activities with PIS in the network, which was confirmed by all data collection mechanisms.

Of the five activities added to the logical models in relation to the text of the PDPIS, all refer to the dissemination of information and knowledge about PIS. The model becomes plausible as these actions are included.

The response options provided for prioritization of evaluation by the participants were grouped into three groups: precursory aspects of the implementation of PIS services; aspects related to the functioning of these services; and aspects related to the expected effects with the implementation of the PDPIS (*table 1*).

Table 1. Aspects indicated by the 38 stakeholders as priorities for evaluation in relation to the implementation of the PDPIS DF, 2020

	GROUP OF STAKEHOLDERS					
Aspects of the evaluation	**Facilitators (17)**	**PIS managers (9)**	**Central health managers (3)**	**Regional health managers (6)**	**Health Council (3)**	**TOTAL (38)**
Precursors of the implementation of PIS services: availability of necessary resources for execution (18); professional training for PIS or professional regulation for PIS (13); planning, conception, reasoning of the policy (7); scientific knowledge related to PIS (6); budget or financing of PIS-related policy and regulation (4 each); related popular knowledge (2); top management's understanding of what it is and how important it is (1, in 'others')	27	7	5	11	5	55
Functioning of PIS services: operationalization and improvement of the services of each PIS (12); needs/demands of the target audience (10); favorable or unfavorable context and obstacles to implementation (5); feasibility of different PIS services (4); differences between implantation sites, strengths and weaknesses (3); how much each service is sought after or reaches the target audience, possibilities or effectiveness of attempts at improvement and if there was a planned implementation (2 each); support from local leaders (1, in 'others').	15	12	4	6	4	41
Effects of implementing the PDPIS: offer and experiences already carried out (6); range of expected or unexpected effects of the policy, in the short, medium or long term (4); effects of the implementation of each PIS (3); cost-benefit of practices (3); and elements necessary for the effectiveness of the Policy or each PIS (3)	8	8	2	1	0	19
TOTAL	**50**	**27**	**11**	**18**	**9**	**115**

Source: Own elaboration.

The first set predominated in the general total of answers, with emphasis on the availability of resources and training or professional regulation for PIS. However, this did not have a uniform response among the consulted groups, as it was not prioritized by groups of central managers.

Only for the GERPIS group did the second set of aspects predominate in the answers, but the operationalization and improvement of PIS services was the third most prioritized option for evaluation by the participants in general, registered by all groups.

Apparently, the central management of PIS perceives itself to be in hold of issues that are precursors to the implementation of services that the rest of the stakeholders involved in this study are not. This reinforces the need for education on the use of PIS as care technologies. At the same time, monitoring does not seem to be enough to provide central management with sufficient information about the operation of network services, in order to improve management.

The knowledge and perception of the functioning of the PIS services, the mechanism of action and the rationale for these practices, seems to be a critical point in the implementation of the PDPIS. Without understanding and acting on this node, the implementation and execution of services becomes difficult, without which their purpose cannot be achieved.

It is noteworthy that the development of the study allowed expanding the vision of managers and others involved with the PIS on the policy and its implementation[20], as well as its results fostering communication and knowledge for all who access them.

The evaluative questions, the last stage of the EA carried out, must translate the desire and need for understanding of the actors, in addition to being able to show directions that add value to the evaluated object, recognizing its results or illuminating its limitations[35]. Two central questions were identified:

- Do the actors involved know and exercise their responsibilities in providing the necessary resources for the implementation of PIS in light of the institutional norms of the SES-DF?

- Do public servants qualified to provide assistance with PIS and their managers feel that they have the intellectual resources needed to perform the services?

Discussion

The centralized responsibility in GERPIS and the little definition of financial resources are aspects identified for improving the implementation of the PDPIS, which can be favored with this study. However, the implementation has been maintained and expanded over time, with a network of actors internal and external to the SES-DF, including users and those who work in a technical and educational way.

The structure of the PDPIS text included almost all the elements described by the Ministry of Health36 as necessary to fulfill its purpose. This study enabled the recognition and modeling of its constituent elements, advancing in relation to the necessary logical organization for monitoring and evaluation.

The PDPIS guidelines identified in this study coincide approximately with the components described for the Recife Municipal Policy for Integrative Practices[37]. They "express achievement ideals and guide strategic and priority choices"[38(104)]. They indicate lines of action to be followed or paths of action for the elaboration of plans, programs, projects and activities that will make the policy operational, serving as a foundation for the actions of managers[36].

The guideline on guaranteeing access to homeopathic, anthroposophic, medicinal plants and herbal medicines, in the original text, despite the growth and appreciation of the two units of Live Pharmacy implemented, was not feasible, due to the unavailability of resources, technologies and structure, aspects mentioned by Mendes et al.[39].

To explore aspects of evaluation, monitoring or improvement of the policy, it is necessary to consider its innovative proposal in the current national context of health services and its implementation limitations, with clear weaknesses in monitoring. Even so, the offer and monitoring of these practices in the DF stand out, considering that the data available in Brazil on Pics is scarce and even the offer is still timid, despite the positive effects for users and services that use them[15].

The logical design constructed and presented here can support other planning instruments, which can be part of or derived from the text of the policy, favoring the existence of parameters, criteria and indicators for planning, monitoring and evaluating its execution, in addition to specifying quantitative and qualitative goals, that may or may not be included in official government plans.

Considering that a policy is a general planning instrument, eliminating the need to quantify objectives, targets and resources[36], the use of more targeted and detailed management instruments than the policy itself would allow for easy readjustment and faithful representation of the implementation reality over the years, without the need to adjust the core of the policy, its purpose and its guidelines.

The set of modeled information allows a first look at the implementation reality, but requires periodic updates to represent reality. Likewise, the modeling of educational actions with managers and professionals may be able to assist in decision-making for future adjustments, with the potential to qualify the response of the health system[40].

The modeled intervention is comprehensive and complex, provoking questions and reflections that require flexibility and adjustments to the particularities of each context involved[41,42]. In this sense, the generated models were able to logically represent the main components for the operationalization of the policy under study, but could not bring about many advances in relational aspects that interfere with its implementation.

The human aspects need to be explored, as the interprofessional relationships themselves can affect and be positively affected by the implementation of Pics in health units, for a complex of reasons, including the hierarchy of powers in the traditional training of professionals in contrast to the greater horizontality in the dissemination and use of knowledge of Pics[11].

Despite the specific Pics policies in the country, the implementation often occurs independently by the interested professionals themselves[10,43], lacking resources for its realization. For this reason, studying Pics management can be a tendency to support the growth and quality of the offer[43], since the practice implemented, financed and developed directly by professionals, without management support, would not characterize a State policy, generating instability in the offer[7].

Even with a good level of education – 65.8% of participants reporting a specialization or master's degree – specific training for Pics is one of the limitations to the expansion process. There is little national regulation, insertion of the subject in teaching is incipient and experiences in permanent education in Pics are local[9,10]. Access to inputs is also fundamental for the quality of services and the resolvability of health care[12,14].

It is known that there is a political and technical lack of preparation of health professionals to work with Pics in the SUS, being necessary, for its consolidation in the network, educational processes that train professionals in line with the SUS guidelines and with the principles of Collective Health[15,44]. The training of professionals for Pics in the SUS should receive special attention, so that there is responsibility and understanding of its potentialities and limits, avoiding trivialization or misuse[43].

This is not restricted to PIS. Other studies on health promotion identified the need to strengthen formal education and expand articulated intersectoral actions[45], in addition to the desire to expand material and immaterial resources to consolidate processes[46].

Thus, with the purpose of answering questions and gaps in knowledge about the intervention, its operation and results, the importance of formative evaluations is highlighted, seeking to improve the program in the course of its execution and with the involvement of the actors[42,47,48].

It is suggested to focus on the set of resources necessary for the operation of PIS services in the health network, so that managers and other actors also appropriate intellectual resources on PIS, obtaining knowledge about the functioning of these services in the network, in order to complement their health care management framework.

Final considerations

Carrying out the study made it possible to clarify and align the elements of the PDPIS in a coherent way, in the current context, with the consensus of the interested parties involved. This makes it possible to explore aspects to be evaluated, monitored or improved.

The participation of those interested in the construction and validation of the modeling

carried out facilitates the understanding and execution of elementary aspects of the logical chain of implementation of the policy throughout the network, which can have repercussions on improving its operation in the short, medium and long term.

In addition, the generated logical models can be adjusted whenever there are changes in the scenario, as well as be used for planning, executing, monitoring and improving the implementation of the PDPIS, in a network, to achieve its purpose.

The modeling of the district policy makes it possible to advance towards studies of each PIS and its operationalization in the Health Regions of the DF. Other levels of health care and the context outside the SES – limitations of this study – could also be more easily explored.

It is suggested to encourage the set of resources needed to implement the PDPIS together with conventional health services, with emphasis on knowledge about PIS and related sectoral and intersectoral responsibilities.

The elaboration of action plans derived from the policy can be a good opportunity to agree on these responsibilities, favoring decentralized actions to meet local needs. It is hoped that this article can contribute to the development of PIS in the country.

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Collaborators

Lemos MPK (0000-0002-4717-3633)* contributed to the study design, data collection and analysis, structuring, writing and approval of the final version of the article. Luiza VL (0000-0001-6245-7522)* contributed to data analysis, writing and approval of the final version of the article. ■

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