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ORIGINAL ARTICLE

Implementation of Biodanza as an Integrative and Complementary Practice within Brazil's Unified Health System

Implementação da Biodança no contexto das Práticas Integrativas e Complementares no Sistema Único de Saúde no Brasil

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ABSTRACT This study sought to understand and analyze the conditions for implementing Biodanza within as an Integrative and Complementary Practice in Brazil's Unified Health System. It employed a qualitative, exploratory, and descriptive design, with data collected between September–November 2021. The study population consisted of Biodanza facilitators who were working or had previously worked in any SUS service setting since the incorporation of the practice in March 2017, regardless of professional affiliation. Participants were recruited through snowball sampling, and semi-structured interviews were conducted with 25 individuals. The findings revealed key aspects characterizing this early stage of implementation. Although institutionalization remains limited, Biodanza exhibited potential contributions both as a complementary therapeutic resource to biomedicine and as an alternative paradigm for health care. Therefore, this study informs health professionals, managers, and scholars about Biodanza and supports dialogue to improve and expand its availability within SUS.

KEYWORDS Biodanza. Integrative and Complementary Practices. Implementation science. Unified Health System. Public health.

RESUMO *A pesquisa buscou compreender e analisar as condições de implementação da Biodança no contexto das Práticas Integrativas e Complementares no Sistema Único de Saúde (SUS). Trata-se de um estudo qualitativo, exploratório e descritivo, com a coleta de dados realizada entre setembro e novembro de 2021, tendo como sujeitos do estudo facilitadores de Biodança que estivessem atuando ou tenham atuado em algum serviço do SUS, independentemente do vínculo profissional, a partir do período de inclusão da Biodança no SUS, ou seja, março de 2017. A amostra foi recrutada por meio da técnica snowball sampling (bola de neve), tendo sido realizadas entrevistas semiestruturadas com os 25 participantes. Os dados coletados foram submetidos à análise de conteúdo temática. Os resultados reúnem elementos importantes para compreender o estado atual da arte de uma implementação incipiente, com fragilidades na institucionalização e que, ao mesmo tempo, demonstra contribuições para a resolutividade enquanto recurso terapêutico complementar à biomedicina e como novo paradigma de cuidado em saúde. Oferece aos profissionais de saúde, gestores e academia a possibilidade de aproximação, conhecimento da Biodança e diálogo para a melhoria e ampliação da oferta no sistema público de saúde brasileiro.*

PALAVRAS-CHAVE *Biodança. Práticas Integrativas e Complementares. Ciência da implementação. Sistema Único de Saúde. Saúde pública.*

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Introduction

The creation of Brazil's Unified Health System (SUS) marked a paradigmatic shift that broadened the concept of health, following the Brazilian Health Reform and World Health Organization recommendations. It affirmed health as a universal right and opened space for forms of care that incorporate other rationalities, such as culture, traditional knowledge, and the pursuit of integrality of being.

This shift was a response to the social crises of the late twentieth and early twenty-first centuries, accompanied by new paradigms of society and health that aimed to reestablish the relationship between human beings, nature, and their own essence. Within this context of reconnecting with human origins, millennia-old forms of care have re-emerged[1,2].

Nevertheless, the paradigm shift proposed by SUS has been challenging. It requires moving away from entrenched processes inherited from a hegemonic biomedical model (e.g., curative, hospital-centered, and heavily influenced by the pharmaceutical industry) toward an integrative model of care that is de-medicalizing and life-promoting. Various public policies were developed and implemented within SUS to support this transition, the most prominent of which is the National Policy on Integrative and Complementary Practices[3] (NPICP). In its initial formulation, the policy included five practices in the SUS catalogue of procedures: homeopathy, phytotherapy (medicinal plants), acupuncture (traditional Chinese medicine), anthroposophic medicine, and social thermalism (crenotherapy). Although viewed by some as limited given the range of existing practices, the NPICP was pivotal in expanding the culture of care and encouraging managers and health professionals to adopt new approaches to health care[1].

Integrative and Complementary Practices (ICPs), internationally referred to as traditional, complementary, and integrative medicine, are complex systems or institutionalized therapeutic resources within SUS. They have gained prominence in public health since the 1980s in efforts to achieve institutional integration and academic legitimacy[4]. The ICPs' institutionalization in SUS expanded in March 2017, incorporating 14 additional practices, including Biodanza[5], and again in March 2018, encompassing ten more practices[6], totaling 29. This expansion broadened care approaches and therapeutic options, promoting greater integrality and system responsiveness in health care.

Biodanza, an internationally registered trademark and the nomenclature adopted in this study, originated in Santiago, Chile, created by the psychologist, anthropologist, educator, and poet Rolando Toro Araneda. He sought to implement dance as an unconventional therapeutic approach within Chilean psychiatry[7]. Toro defines Biodanza as a system of human development and integration that operates by fostering a fundamental sense of connection with life. Through this process, individuals reconnect with themselves, with the species, and with the universe, all within a group-centered affective framework. The system aims to promote organic renewal, the maintenance of homeostatic harmony, or the organism's organic stability. It also involves affective re-education, supporting transformations in the ways of being, acting, and relating to the world, as well as the relearning of life's original functions, which entails reevaluating human behavior and lifestyle according to basic instincts. Within experiences that mobilize the living's natural movement, Biodanza utilizes dance, music, singing, gestures, and specific and archetypal movements to integrate the cognitive, emotional, spiritual, and evolutionary functions of the human being, drawing on a repertoire of music and exercises developed by an international scientific committee[8].

Although Biodanza was only recently included in the NPICP, it has been documented in Brazilian public health since the 1980s, even before the creation of SUS. Health professionals with training in, or affinity for, Biodanza

promoted its use, seeking partnerships with non-governmental organizations and training schools to humanize health care[9].

There is little research on Biodanza related to SUS, and to public and collective health. Therefore, this study aimed to analyze its implementation as an ICP within SUS, examining how Biodanza has been introduced into health care and the conditions surrounding this process.

Material and methods

A qualitative, exploratory, and descriptive study was conducted to analyze the implementation of Biodanza within SUS. Semi-structured interviews were carried out with Biodanza facilitators working in SUS, regardless of professional background, covering the period from March 2017, when Biodanza was incorporated into the NPICP, to November 2021.

Participants were recruited using the snowball sampling technique between September–November 2021. According to Vinuto[10], this non-probabilistic sampling method uses referral chains (a type of network) initiated by key informants, or 'seeds,' who belong to the same community or population. These seeds then refer individuals in their social or professional networks who meet the inclusion criteria; these referrals are considered the 'offspring' of the seeds.

In this study, the seeds were four Biodanza facilitators from the researcher's professional network, who were also Biodanza facilitators. Two seeds are members of the BIOSUS Working and Study Group of the Brazilian Association of Biodanza Facilitators (ABRAÇA) and identified other facilitators in the association who work in SUS. These facilitators then referred others in their networks, resulting in a total of 31 facilitators across Brazil, except the northern region. One later withdrew, two could not participate due to family health issues, and three did not meet the inclusion criteria (one had worked in SUS only until 2015, one works at a university, and one at a Social Assistance Reference Center [CRAS]). Ultimately, 25 facilitators were interviewed (*table 1*).

Table 1. Interviewee characteristics and profiles

Interviewee	Sex	Age	State	Region	Level of education	Occupation	Service setting	SUS affiliation
E1	F	61/70	SC	S	Specialization degree	Physician	FHS	Permanent staff
E2	M	61/70	AL	NE	Specialization degree	Accountant	Health Academy Program	Contract
E3	F	41/50	PE	NE	Specialization degree	Psychologist	Specialized unit in ICPs	Contract
E4	F	61/70	BA	NE	Undergraduate degree	Instructor	University hospital	Volunteer
E5	M	51/60	PE	NE	Specialization degree	Psychologist	CAPS	Permanent staff
E6	M	31/40	BA	NE	Master's degree	Nurse	CAPS	Volunteer
E7	M	51/60	PB	NE	Specialization degree	Instructor	Specialized unit in ICPs	Volunteer
E8	M	51/60	CE	NE	Specialization degree	Community health agent	FHS	Permanent staff
E9	F	71/80	MG	SE	Master's degree	Instructor	CAPS	Volunteer
E10	F	51/60	DF	CW	Specialization degree	Nutritionist	FHS	Permanent staff
E11	F	51/60	BA	NE	Specialization degree	Social worker	General hospital	Volunteer
E12	F	41/50	CE	NE	Specialization degree	Social worker	CREAS	Manager, Contract
E13	M	31/40	PB	NE	Undergraduate degree	Musician	Specialized unit in ICPs	Volunteer
E14	F	31/40	PB	NE	Specialization degree	Psychologist	Specialized unit in ICPs	Contract

Table 1. Interviewee characteristics and profiles

Interviewee	Sex	Age	State	Region	Level of education	Occupation	Service setting	SUS affiliation
E15	F	61/70	DF	CW	Specialization degree	Chemist	FHS	Volunteer
E16	F	51/60	SP	SE	Master's degree	Occupational therapist	CEREST	Permanent staff
E17	M	51/60	RN	NE	Master's degree	Psychologist	Psychiatric hospital	Permanent staff
E18	F	71/80	BA	NE	Master's degree	Instructor	CAPS	Volunteer
E19	F	51/60	RS	S	Undergraduate degree	Instructor	FHS	Volunteer
E20	F	41/60	SC	S	Undergraduate degree	Instructor	FHS	Volunteer
E21	F	61/70	SC	S	Specialization degree	Physician	FHS	Permanent staff
E22	F	31/40	PB	NE	Undergraduate degree	Instructor	Specialized unit in ICPs	Volunteer
E23	F	51/60	PE	NE	Specialization degree	Occupational therapist	CAPS, Psychiatric hospital	Volunteer
E24	F	31/40	PE	NE	Medical residency	Psychologist	CAPS AD	Permanent staff
E25	M	51/60	SC	S	Master's degree	Dentist	FHS	Volunteer

Source: Prepared by the authors.

CAPS: Psychosocial Care Centers; CEREST: Worker Health Reference Centers; CREAS: Specialized Social Assistance Reference Center; FHS: Family Health Strategy; CAPS AD: Psychosocial Care Centers for Alcohol and Drugs.

This study examined the implementation of Biodanza within SUS and the work of the professionals involved, focusing on its modes of incorporation, SUS services in which it is offered, its organizational functioning, infrastructure, and working conditions; and managerial implications of its implementation.

Data analysis employed thematic content analysis[11], using the category generation technique for subsequent examination of textual elements. Responses were grouped according to the most relevant content and then associated with one another. As the raw data were organized, each report received an identification label[12]. Interviews were labeled with the letter 'I' for interviewee, followed by a number indicating the order in which they were conducted. The semi-structured interviews were conducted on the Zoom platform from September to November 2021 and lasted approximately 80 seconds each.

This study was approved by the research ethics committee (CAAE no. 50824821.1.0000.5208; protocol no. 4,962,189) in accordance with CNS/MS Resolution No. 466/2012[13]. All participants signed the free and informed consent form for virtual data collection.

Results and discussion

This study examined the incorporation and implementation of Biodanza within SUS as an ICP. Geographically, it demonstrated that Biodanza has been adopted mainly in capital cities and metropolitan areas. The northeastern region accounted for 64% of the Biodanza facilitators interviewed, who collectively work across the states of Alagoas, Bahia, Ceará, Pernambuco, Paraíba, and Rio Grande do Norte. The southern region followed with 20%, represented by facilitators active in Santa Catarina and Rio Grande do Sul. In third place were the southeastern (Minas Gerais and São Paulo) and the central-western (Distrito Federal) regions, which together comprised 8% of facilitators working in SUS. Among those interviewed, Biodanza is offered in municipalities only in Alagoas, Bahia, and Minas Gerais. This finding may be related to the concentration of Biodanza training schools in capitals and metropolitan areas, as reported by interviewees.

Implementation occurs in three forms. It may be conducted by health professionals with permanent positions or contracts, who

are either trained in Biodanza or have later pursued such training, by Biodanza interns through agreements between training schools and local health departments, or by Biodanza facilitators who join services as volunteers after submitting intervention projects.

We also identified various factors that support the more effective implementation of Biodanza. Implementation improves when the service team (and, when possible, the management) participates in introductory presentations and theoretical-methodological orientations, especially when the sessions provide opportunities to experience the practice.

> *[...] Before introducing Biodanza in SUS or elsewhere, I always made sure to prepare a solid project, back it up, and offer an initial session so people could understand how the practice works. [...] I never showed up asking for a room, for participants, or laying down rules out of nowhere [...].* (I16).

Similar to other ICPs, Biodanza is essentially experiential, and direct experience provides the best understanding of its proposal. This approach often secures the support needed, and when necessary, a more suitable structure for adopting Biodanza as an additional therapeutic resource, expanding the complementary treatments available to users. Moreover, other professionals may access the basic information needed to prescribe or recommend the practice.

Credibility and trust within the team were also crucial for successful implementation, especially when feedback was available in case discussions or in users' reports during medical consultations.

> *[...] we discussed cases. [...] the medical team, which everyone says is very resistant, sent me many referrals to join the groups, since in consultations the patients who did Biodanza [...] reported that they were improving. They described positive results.* (I16).

Another important finding concerns the role of medical professionals trained in Biodanza. When they introduce the practice, participants are more likely to keep attending, which strengthens implementation. In addition to the trust placed in the professionals, the community health agents were highlighted in several interviews as a crucial aspect, since they mobilize, guide, and motivate users to join and continue participating in the Biodanza group.

> *[...] I worked as a physician in that health center [...] and that was one of the things that made it easier for me to get in, to form a group [...] I prepared several little notes, gave them to the community health agents to hand out, and people would say, 'But what is this?' Others would spread the word: 'I don't know, but if Dr. B. recommended it, then it must be good, right?' So there was that trust, you know? Both in me and in the agents. I always relied on the community health agents for everything [...].* (I1).

Nonetheless, a paradox emerges within the biomedical model: when a medical professional implements Biodanza, the community, other professionals, and management may accept it in some instances and react with resistance or unfamiliarity in others. Thus, the integrative model of health care, central to the creation of SUS, needs to be reconsidered, as it conceives health as intersectoral and multidimensional and, consequently, requires interprofessional practices informed by a systemic perspective[1].

> *[...] at first the team didn't value it [...] and neither did the community. 'The doctor isn't at the unit, she's there again with that group, she only cares about music and dancing' [...] There were comments like that. [...] The management itself [...] shut down my group because I should be at the unit doing consultations and writing prescriptions. [...] I had to put together a dossier of all the experiences [...] to defend the right for a doctor to keep a Biodanza group [...] to make management understand that doctors don't only prescribe, they promote health [...].* (I1).

This excerpt demonstrates how essential professional clarity is for professional fulfillment and for implementing Biodanza within SUS. When professionals recognize their role in advancing a new model of health care, their decision to integrate Biodanza into their practice is guided by commitment and supported by empirical evidence. In this context, implementation is further reinforced by health professionals participating in regular groups, which foster new behaviors in organizational dynamics and work processes.

> *[...] as they participate, [...] their attitude toward the patients changed completely [...] it's a high--risk, very aggressive community, so sometimes fights would break out at the clinic between staff and patients, right? With Biodanza, that stopped, you know? [...].* (I21).

These findings corroborate Barros et al.[14], who argue that ICPs in Primary Health Care (PHC) contribute to technical and technological innovation in organizational arrangements and work processes. As a work process, their studies indicated improvements in work quality by integrating a sense of professional satisfaction and promoting a paradigm shift from pathogenesis to prevention and health promotion. In organizational terms, several changes were also observed: greater integration among professionals and stronger connections with users, supporting the decentralization of care and its organization around users and their needs, a shift from an individual, curative model to a more horizontal one, countering the vertical relationships that hinder interprofessionality, and more balanced power relations, accompanied by gains in communication, shared decision-making, and attentive, respectful listening.

According to the interviewees, 48% of Biodanza activities are offered in PHC, specifically within the Family Health Strategy and the Health Academy, 43% are delivered in medium complexity services (Psychosocial Care Centers [CAPS], Worker Health Reference Centers, and specialized units in ICPs); and 9% are provided in high complexity settings (general, university, and psychiatric hospitals), as shown in *table 1*.

Since primary care is the preferred setting for these practices, Biodanza is more widely offered in PHC. This preference stems from its central role in promoting horizontal, supportive, longitudinal, comprehensive, and universal care, as well as from its function as the first point of contact within SUS, as noted in the Manual for the Implementation of ICPs in SUS[15].

Each service generally conducts one to five weekly Biodanza groups, with approximately 20–50 users per group. Some services divide participants into beginner, intermediate, and advanced groups. Toro[7] characterizes advanced groups as those marked by a high level of self-awareness and self-confidence, both individually and collectively, with deeper, more structural changes in users' lives[16]. Nevertheless, participants in beginner or intermediate groups can also reach these levels. The interviewees observed that structural constraints, high turnover, and organizing the program without considering specific care needs and placing users with diverse health conditions in the same group impede such progress.

> *It's difficult to establish in-depth groups when there is turnover [...]. The spaces are not adequate, don't guarantee privacy or confidentiality, people from outside the group walk in and out or stand around watching [...].* (I3).

> *[...] a cardiac patient can't do the energizing exercises needed for someone with depression, a person with anxiety will need more regressive exercises, not recommended for someone who is psychotic [...] it's a challenge [...] this is not comprehensive, equitable care [...].* (I13).

The organization of Biodanza reproduced the private model of service delivery. No participation length was defined *a priori*, nor were discharge procedures established, resulting

in unmet demand given the strong interest in the service. Only two interviewees reported that discharge is established as a standard procedure to admit new users. A third interviewee developed a three-month participation protocol to accommodate as many users as possible and prevent unmet demand In other words, there is no single Biodanza protocol to be followed within SUS.

> *[...] when someone came to Biodanza, they already knew about the three-month protocol; they could even return with another referral [...] you can't just keep a group open indefinitely. [...] You need to maintain a certain objectivity [...] to allow other people to receive at least this minimal level of care through Biodanza [...] to open doors and let people realize that there is a way forward [...].* (I16).

Moreover, 60% of the interviewees reported that they do not organize services, such as record-keeping, systematization, and follow-up through medical documentation, although medical records are available and include reception notes and clinical histories. This systematic updating of records does not occur for several reasons: services may not formally require it; the number of users per group may be high, limiting the time available to facilitators; or facilitators may be volunteers or interns, in which case record-keeping is not permitted. However, in some services where documentation is mandatory or strongly emphasized, for instance, CAPS, permanent staff (formally employed under Brazil's labor law system or contracted professionals) are expected to record all Biodanza activities. In contrast, within e-SUS, only 12% of interviewees indicated that they perform this type of documentation. As a result, Biodanza is clearly underreported within the ICPs offered in SUS.

Beyond health promotion, mental health (i.e., where Biodanza originally emerged), is a significant area of its inclusion in SUS. Among the interviewees, 25% work in CAPS or psychiatric hospitals, 10% as volunteers, and 15% as permanent staff.

Another finding was the lack of formal selection processes or civil servant exams for Biodanza facilitators, which reflects the precarious conditions under which these professionals work in SUS. Implementation and expansion are hindered by the fact that volunteers and interns account for roughly 70% of the sample. Among the remaining 30% who are employed, hiring often prioritizes Biodanza professionals trained in other ICPs or who can take on extra functions, from administrative tasks to responsibilities linked to their health-training. The techniques may change, albeit within a productivist model that continues to privilege productivity over individuals.

> *[...] most therapists are on temporary contracts, only a few are permanent staff, and many are volunteers. In Biodanza specifically, I was the only one who was hired (on a contract basis), and there were another five Biodanza facilitators who were volunteers [...] the director would only hire people who had a health-related degree and some other practice [...] and if a worker didn't mention it, or if they only had one practice [...] the person would stay, but they would end up doing other things [...].* (I14).

In addition to precarious working conditions, which stem from the absence of specific funding in the NPICP[17] to support another healthcare paradigm[1], we identified several challenges specific to implementing Biodanza within SUS, and challenges common to other ICPs, including infrastructure limitations.

Most services offer precarious infrastructure for Biodanza, leading facilitators to rely on community spaces that provide adequate ventilation, privacy, toilets, and drinking water. Spaces associated with Catholic parishes or residents' associations are common alternatives. In addition, in 95% of services, facilitators must provide and transport their own sound equipment, including a computer, smartphone, and speaker.

However, specialized ICP units, the Health Academy Program, hospitals, and certain

CAPS presented different conditions: rooms that could accommodate the group size, were air-conditioned, and ensured privacy and confidentiality. These differences in infrastructure largely reflect the work team and management's level of engagement, which increasingly appears to be a *sine qua non* condition for successfully implementing Biodanza within SUS.

Conversely, the findings revealed that the implementation of Biodanza and continuity in SUS depend primarily on the ICP team, while management remains absent or distant from the process. This managerial distancing hinders accurate monitoring of outcomes. Accordingly, the results underscore the importance of tracking user results, including reductions in medication use, as noted by one of the interviewees:

> *[...] it's extremely important [...] for management [...] to pay close attention to the outcomes achieved through Biodanza and other ICPs, such as reductions in medication use, for example. What isn't spent on medications could very well be used to hire more people in Biodanza or in other ICPs [...].* (I7).

There is also a need to establish care spaces within ICPs for health professionals, as noted by another interviewee:

> *[...] that the professionals themselves also need to be cared for [...] the professional needs care because they are a caregiver, when they are cared for, they feel better, they treat users better, they relate better to their colleagues, and their life improves [...].* (I8).

Various interviewees observed that management and professionals are attentive to service quality, which they view as a challenge given the practice's structural, labor, organizational, and operational conditions. Creating an evaluation protocol would allow facilitators to assess outcomes more consistently.

Another key finding, led by a manager trained in Biodanza, was the practice's intersectoral implementation across public policies, integrating areas such as the Unified Social Assistance System, education, and SUS. The initiative arose from the health unit's lack of adequate physical space, prompting collaboration between the Family Health Strategy and Social Assistance Reference Center, enabling them to address challenges jointly and promote health. The interviewee stated that Biodanza fostered changes in individuals, in community dynamics, and in work processes in both SUS and Unified Social Assistance System.

> *[...] Results that neither Unified Social Assistance System nor SUS would be able to achieve on their own. We can mediate conflicts, restore lives, rebuild community bonds, strengthen community solidarity, and help the community recover its capacity to dream and hope for better days. [...] It even contributed to a new atmosphere within the CRAS team and in our relationship with the Family Health Strategy, it almost feels like we are a single team, CRAS and Family Health Strategy, because of how integrated we have become [...].* (I12).

The findings demonstrate that Biodanza facilitators are fundamental to its implementation. A similar dynamic occurs with other ICPS, highlighting the fragility of their institutionalization. In practice, health professionals are the ones who coordinate these activities, from initiating and sustaining the activities to expanding and even funding them, while management frequently remains uninvolved. As a result, ICPs are marked by instability. When these professionals, often in non-permanent positions, leave the service or discontinue their involvement for any reason, the practice is no longer offered, reflecting a policy of the individual, and not of the state[18].

Barro et al.[19] posited that The challenges for implementing ICPs are clear and of various kinds: training and qualification of

professionals; monitoring and evaluation of services; provision of supplies; structuring of services in the public network; need for development and adaptation of specific legislation; lack of investment in research and development of processes and products; lack of support from municipal management, leading to individual and specific initiatives, led by professionals, many of them voluntary, to offer ICPs in PHC services; as well as the need to broaden the meanings of professional practice anchored in integrative principles and a sociability guided by holistic values.

The success of such a model for implementing ICPs in PHC will only be achieved when a set of strategies involving policy, management, human resources, the local culture of work organization, available resources, among others, is considered; added to a collaborative attitude from the entire work team, in order to support a change in thinking and, consequently, a cultural change in the practice of health care. All of this is intertwined with the users' interest and willingness to receive such care, the doctors' openness to this care model, along with other professional categories, and the perception of the ideology contained in the ICPs, which is consistent with the principle of comprehensiveness, advocated by the SUS[20-22].

Given the above, it is important to note that, since 2018, a technical note on Biodanza has been available, prepared by the Department of Health Actions of the State Health Agency of Rio Grande do Sul in partnership with Associations of Facilitators and Biodanza Schools. This document compiles accurate information on Biodanza and its applicability, offering managers the technical guidance needed for implementation across municipalities and states[23]. Additionally, ABRAÇA has produced a research report on Biodanza facilitators in SUS[24]. These types of initiatives are crucial for addressing the challenges of introducing and implementing Biodanza in SUS.

Final considerations

Given the pioneering nature and significance of this study, and the absence of previously published works on Biodanza within the framework of SUS and community health, this research aimed to ethically and politically incorporate Biodanza into the body of scientific evidence for IPC health practices within the SUS.

Despite incipient, our study assembled significant elements contributing to this implementation from the critical and attentive perspective of Biodanza facilitators involved with SUS. These facilitators have been the main agents responsible for the integration, organization, expansion, maintenance, and even financing of Biodanza across the three levels of SUS care. Their leadership, contrasted with the minimal involvement of management, highlights the nascent and fragile nature of Biodanza's implementation within the SUS. Despite being practiced in various settings and public health services since the 1980s, prior to the establishment of the SUS, it remains largely confined to specific geographical areas (i.e., capitals and metropolitan regions).

Our findings indicated the importance of developing protocols that standardize the practice of Biodanza to address the specific needs of SUS users and to determine the optimal duration for participation in groups. Another crucial aspect is the need for increased investment in the hiring of new professionals. These insights merit the attention of management, academia (due to its educational mission), SUS health professionals, and private institutions that train and advocate for this practice.

It is believed that this study does not end here but rather paves the way for further research, especially regarding the timely dialogue between management, academia, health professionals, Biodanza schools, and facilitators concerning the positive impacts of Biodanza on SUS as an Integrative and Complementary Practice for the health of the Brazilian population.

Collaborators

Santos CR (0009-0008-7088-1487)* contributed to the study's conceptual and theoretical-methodological design, data collection, analysis and interpretation, writing, and critical revision and final approval of the manuscript. Guimarães MBL (0000-0001-8554-600X)* contributed to the conceptual and theoretical-methodological design, data analysis and interpretation, writing, and critical revision and final approval of the manuscript. Bezerra AFB (0000-0002-5278-3727)* and Costa SB (0000-0002-5088-4006)* contributed equally to the critical revision and final approval of the manuscript. ■

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