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DOI: 10.1590/1413-81232015219.15472016

The implementation of the *Mais Médicos* (More Doctors) Program and comprehensiveness of care in the Family Health Strategy

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Abstract *The* Mais Médicos (*More Doctors) Program is a Brazilian government program that aims to expand access to medical care and thus improve the quality of primary healthcare delivery. This study aims to analyze the perceptions of nondoctor members of the Family Health Strategy teams regarding comprehensiveness of care after the inclusion of doctors from the program. The study encompassed 32 poor municipalities in Brazil's five geographical regions. A total of 78 health workers were interviewed. The interviews were transcribed and analyzed using content analysis and the software Atlas.ti Version 1.0.36. The study found that the program led to: an increase in access to and accessibility of services provided under the Family Health Strategy; humanized care and the establishment of bonds - understanding, partnership, friendship and respect; going back to clinical approaches - dedicated time, listening attentively, and detailed physical examination; the desire and willingness to resolve problems; continuity of care; guarenteeing home visits; and coordination of multidisciplinary teams in networks. It was concluded that the Mais Médicos Program contributed to the enhancement of comprehensiveness, thus leading to improvements in primary health care delivery.*

Key words *Comprehensive Health Care, Family Health Strategy, National Health Programs, Unified Health System*

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Introduction

Primary health care coverage in Brazil has increased considerably since the introduction of the Family Health Strategy (*Estratégia Saúde da Família* - ESF) in 1994. Despite the advances made over the last two decades, the primary health care system continues to face important challenges[1]. The assessment of these advances and challenges is an important element in measuring health equity across different populations.

In 2011, Decree 7.508, through the National Primary Care Policy, institucionalized the ESF as the main gateway to the Unified Health System (*Sistema Único de Saúde* – SUS), complemented by the urgent and emergency care networks, mental health networks, and special open access services[2].

Comprehensiveness of care is a fundamental feature of primary health care. The concept of comprehensiveness is embodied in the Brazilian constitution as "comprehensive care" (*atendimento integral*)[3] and is one of the guiding principles of the SUS. Mattos[4] defines comprehensiveness as a goal and stresses that its main purpose is to distinguish between what is desired and what exists and attempt to indicate the direction that we wish to impress on the transformation of reality. He goes on to suggest that comprehensiveness is a polysemous concept that has different meanings depending on the situation in which it is applied and propose that is one of the features of good medicine. Comprehensiveness implies taking a holistic view of health service users and considering more than just biological aspects of health problems. Another set of meanings concerns the organization of health service delivery, that is, a critique of the dissociation between public health and care delivery[4], while Starsfield[5] defines comprehensiveness as "the availability and provision of services to meet all but uncommon population needs".

There is a consensus that comprehensiveness - or comprehensive care - encompasses not only care, but also health promotion and prevention and actions that tend to meet the popuation's health needs and the balance between spontaneous demand and scheduled demand, thus enhancing access and accessibility[4-7]. Furthermore, the term is used with reference to the care network and the integration of health services within the SUS[4]. The concept of comprehensiveness therefore has a broad meaning that encompasses various aspects of health care provision, including the management of the health care network and intersectoral actions that respond to the population's health needs[8,9].

The *Mais Médicos* Program

The "More Doctors for Brazil Program" (*Programa Mais Médicos para o Brasil* - PMM) was created in 2013 in response to a request from the National Front of Mayors (*Frente Nacional de Prefeitos*) and public demonstrations demanding improvements to the health service. Its aim was to provide family health teams (*equipes de saúde da família* - EqSF) with doctors, particularly in more remote and isolated municipalities. The *Mais Médicos* program is a strategic government program directed at improving the quality of primary health care services by expanding access to medical care, and consequently enhancing the care network's capacity to provide comprehensive care[9]. Furthermore, the program seeks to promote a shift in the approach to health care from a cure-based focus to disease prevention and promotion.

The *Mais Médicos* program allowed for the immediate inclusion of doctors in EqSFs, created new medical schools, opened new positions to train more doctors in regions that lacked doctors[10], and improved the facilities in primary health care centers (*Unidades Básicas de Health* - UBS). Currently (2015), around 18,000 doctors are working through the program throughout 4,000 municipalities, providing care for 63 million people[11]. The majority of these doctors are not Brazilian and are work through a cooperation program between Brazil and Cuba.

This article aims to describe elements of comprehensiveness reflected in the work of family health teams that have received doctors through the *Mais Médicos* Program. It presents part of the preliminary findings of the research study *An analysis of the effectiveness of the* Mais médicos *initiative in ensuring the universal right to health and consolidating health service networks*", coordinated by the University of Brasília (UnB, acronym in Portuguese). The study was guided by the following questions: (a) Are ESF teams able to incorporate features of comprehensiveness with people trained in another country whose mother tongue is not Portuguese?; (b) Do doctors act in accord with the classic medical model?; (c) if the challenge is comprehensiveness of care, to what extent can this goal be developed through collaborative working within EqSFs that now have a doctor, the majority of whom are non-Brazilian?

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Methodology

A qualitative approach was used, which affords an understanding of recent complex social phenomena[12]. A descriptive case study was undertaken in municipalities selected based on the following inclusion criteria: at least 20% of the population living in extreme poverty; registered in the first or second cycle of the *Mais Médicos* program; has less than five doctors and had less than 0.5 doctors per 1,000 population before the program began in June 2013. A random sample was selected based on a proportional division of the municipalities that met these inclusion criteria using lists of municipalities with random numbers to select 32 municipalities across Brazil's different regions: 14 in the North, 12 in the Northeast, three in the Southeast, two in the Centerwest, and one in the South. A total of 16 states were visited.

A total of 78 semistructured interviews were conducted with members of EqSFs that received doctors: 30 nurses, 27 nursing technicians, 19 community health agents, one pharmacy technician, and one administrative assistant. The *Mais Médicos* program doctors were not interviewed since the study's focus was the perceptions of the other health workers on the inclusion of this new social actor into EqSFs and how this enhanced comprehensive care.

The interviewees mentioned a total of 97 doctors enrolled in the *Mais Médicos* program and working in the selected municipalities. The average age of the doctors was 43 years; 60% were female and 40% male. The majority had been enrolled into the first and second cycles of the *Mais Médicos* program; only nine had enrolled in the third cycle. The large majority of the doctors (78%) were Cuban, 17% were Brazilian, one was Bolivian and one was Spanish.

The interview guide addressed the following aspects: a) interviewees' experiences and understanding of the work carried out by the doctors from the program; b) their evaluation of comprehensiveness in terms of community-health team relations and in relation to the Family Health Support Centers (*Núcleos de Apoio à Estratégia Saúde da Família* - NASF) and other points of care within the SUS (referral and counter-referral); c) how they worked to meet the needs the population's health needs; and, d) how were the *Mais Médicos* program doctors' perspectives incorporated into clinical and community practice? The interviews lasted an average of 20 minutes. Field work was undertaken between November 2014 and June 2015.

The interviews were analyzed using content analysis techniques[13] and the software Atlas.ti Version 1.0.36 (129)[14].

The study was approved by the Research Ethics Committee of the Faculty of Health Sciences at the University of Brasília and each interviewee signed an informed consent form that explained the study objectives and conditions of participation.

Results and discussion

The following main topics arose from the interviews: interprofessional collaboration and commitment to overcoming the language barrier; increase in access to health services and community confidence in the ESF; making patients feel comfortable - understanding, partnership, friendship, respect; going back to clinical approaches - dedicated time, listening attentively, detailed physical examination and establishing bonds; the desire and willingness to "resolve" problems; guaranteeing home visits; TOGETHER with doctor (a) we are a TEAM; experiences with NASFs.

Interprofessional collaboration and commitment to overcoming the language barrier

An essential element of comprehensiveness is ensuring a welcoming (humanized) environment and establishing bonds of trust between health workers and the community. To create a welcoming environment, good communication between users and health workers is necessary. Given that the majority of the doctors were from Cuba and many did not speak Portuguese, it is essential to ask: *was language an obstacle to comprehensiveness?*

Communication is fundamental for health service user-health worker relations and essential to a creating a welcoming environment that makes patients feel comfortable[15]. The interviewees were unanimous about the fact that in the beginning they did not understand the Cuban doctors very well. However, after some time they began to understand them and communication was fluid: *we don't know the language, we are not going to understand what the doctors say and they are not going to understand what we say... but over time we got used to it.* The Cuban doctors depended on the collaboration of Brazilian workers to overcome this barrier without greater difficulty.

Communication involves not only the capacity to make oneself understood, but also, and above all, actively listening in a warm manner. To sensitize and mobilize people you need to reach them in their 'subjectivity', not only convey information and promote a conceptual understanding[16]. A number of skills are required to ensure that communication flows, not just language; service users should be provided with a "humanized" welcoming environment.

However, communication difficulties occured between doctors and service users, particularly elderly patients with low levels of schooling living in rural areas. However, the interviewees suggested simple solutions for these cases. *In terms of communication,* [...] *because there are a lot of elderly people, people from rual areas, they find it hard to understand what the doctor is saying to them. But the doctor is very patient, she explains things a number of times and when the patient doesn't understand she calls over another health worker to transmit to the patient what she is trying to explain.*

The literature suggests that there is a clear relationship between doctor-patient communication and quality of care, since good communication affords more humanized medical care and leads to improvements in the quality of health services[17,18]. Some studies have addressed the association between communication and adherence to treatment[19].

Increase in community access and accessibility to the ESF

Accessibility and access are essential elements of comprehensiveness of care. According to Barbara Starfield[5], access is the user's experience with the health service. Starfield distinguishes between access and accessibility. The latter depends on the availability of a range of services to meet all health-related needs or a first contact. Other authors define access as the ability of individuals to seek and obtain care[20].

One aspect related to the increase in the number of doctors mentioned by the interviewees as a positive change was a substantial improvement in accessibility. The interviewees' accounts clearly show that before there was a lack of doctors and now they have doctors (accessibility). There is now an available supply of medical appointments and the community can meet these doctors (access). *The community feels more secure, more comfortable when there is a doctor at the center. There are two Cuban doctors in the municipality. Their arrival has unburdened the hospital and the community has easier access.*

Interviewees made the following comments with respect to lack of doctors in the municipalities before the *Mais Médicos* program: total lack, high turnover, and small number of doctors. *Yes, there have been changes, because before we really lacked doctors*; *so the doctor came once, once a month and that was it; now the community has confidence that when they seek treatment in the health center they will find working and accesible doctors*. One of the interviewees mentioned that this has alleviated the pressure on the hospital since people seek care at the health center knowing that there is a permanent doctor.

Some accounts highlight that accessibility and access have improved, since riverine and rural communities now have access to the health service due to the constant availability of doctors under the *Mais Médicos* program and their flexibility in meeting spontaneous demand. *The doctors always see patients, sometimes 5 or 6 appointments more than scheduled, because they also understand the situation of the people from the riverine communities who come to be seen. Sometimes the boat is late or the weather is bad and when they arrive there are no more appointments available.* [...] *This is the sacrifice that service users make, but the doctors see everyone and very well.* The interviewees highlight the doctors' willingness to work after hours and meet spontaneous demand, which is one of the functions of primary doctors[21].

Only one interviewee stated that there was no change in accessibility, because the municipality already had a doctor. Other interviewees highlighted problems related to access to examinations, including mammograms.

The majority of studies conducted in Brazil confirm that advances were made in access and accessibility to health centers while highlighting that barriers to access to examinations, specialist appointments and medications remain a challenge[22]. The present study confirms the same problemas, demonstrating that access and accessibility to medical appointments and health teams have improved, while problems related to access to complimentary examinations persist.

Comprehensiveness in terms of availability and provision of services to meet health needs[5] has therefore improved given that there are more doctors in the health teams and doctors have increased their availability. Furthermore, any practice that favors access and accessibility is seen to enhance comprehensiveness[23].

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Making patients feel comfortable: understanding, partnership, friendship, respect

Another important element comprehensiveness is ensuring a humanized, welcoming environment. A humanized welcoming environment fosters a relationship of trust with the community[24]. Émerson Merhy defines a welcoming environment as a humanized relationship between health workers and health service users and suggests that it is related to the establishment of bonds and sensibility[25]. A welcoming environment implies the reorganization of health services to ensure humanized care, which includes the health team's ability to be sensitive to service users' needs and the possibility of opening the health system's door to all care needs (ensure universal access)[1-26].

The majority of the interviewees highlighted that with the arrival of the doctors from the *Mais Médicos* program the community is assigning greater value to health care. This could be seen as building bonds based on the expectation of a more attentive, accessible and effective health service. *I think that the community is valuing the service a little bit more; service users have also begun to value the care and treatment provided by the doctors and by the team as a whole.*

All interviewees highlighted the strong bond developed by the doctors with the health team and the community. Some of the words used when referring to their work with the doctors include: *understanding, partnership* and *friendship; the relationship is great. Work flows well, there is partnership, understanding, respect. The work is great; the fact that the doctors are not Brazilian does not lead to differences or inequality, the team works well together.*

The above statement is in line with studies that suggest that the establishment of bonds essentially depends on empathy and mutual respect between service providers and the community: after all, bonds cannot be built without the subject, without the freedom of expression of service users, through discussion, judgement and desire.

Furthermore, interviewees highlighted that the new doctors are much more accessible than previous doctors, the *concern* they have for people, and the *care* they have for the community. *More attentive, more communication,* [...] *this project is really good, because if the people can't get to the health center, the doctors go to the people.*

In this case, it was observed that the program enhanced comprehensiveness in the dimension *features of good medicine*[4].

Going back to clinical approaches: dedicated time, listening attentively, detailed physical examination

Patient-centered care is an approach founded on the clinical encounter between the health worker and patient that respects the patient's expressed needs. It requires that the doctor explores both the biomedical dimensions and the patient's perspective of the problem and ensures accurate, complete and mutually understood information and that the patient feels that his/her voice and views are heard and valued. Doctors should continue to develop a relationship and structure appointments to ensure efficiency in information gathering and allow the patient to understand the direction of the medical interview, which should foster a therapeutic aliance that requires time, listening attentively and a detailed physical examination of the patient.

The majority of interviewees provided evidence of humanized care and unanimously highlighted the question of time with respect to appointments. They emphasize the courtesy and dedication of doctors with patients: *the time taken to do the physical examination, the time taken to see the patient, follow-up, treating patients well and the time taken to ensure that the patient feels comfortable;* "*the question of treatment with respect to the physical examination in itself; sometimes our other doctors that work with us here in the municipality didn't have so much time to examine each person; before, the patients complained: ah, the doctor didn't even look me in the face, while these doctors give their full attention.*

The results of the interviews show that the doctors incorporate disease prevention and health promotion into their everyday practice: "*there are not so many sick people anymore. People are coming more for health promotion, for the talks.*

The interviews show that the committment of the *Mais Médicos* program doctors is clearly appreciated by the other members of the health teams. Committment is related to appointment length, detailed examination, making eye contact with the patient, and trust. These biopsychosocial aspects are related to a theoretical perspective that emphasizes the importance of the doctor-patient relationship in the outcome of the disease, affording a greater level of comprehensiveness with respect to the dimension *features of good medicine*[4]. This approach differs from the biomedical model of health, which presupposes generally impersonal patient-doctor relationships.

The desire and willingness to "resolve" the return of the patient

Solvability is another important element of comprehensiveness. In this respect, the interviewees stated that *Mais Médicos* program doctors attempt to develop different strategies to "resolve" the return of the patient after a referral or appointment with a specialist.

Comprehensiveness is also concerned with *continuity of care* through services offered by the SUS coordinated by the ESF, including collaborative working among the members of the EqSFs and between different teams working in the care network, such as specialized outpatient, hospital, mental health, and emergency care networks.

Continuity of care may be defined as the path of events between one appointment and another for a specific health problem, including the transfer of information to make decisions about patient treatment[5]. The concept of lasting therapeutic relationships implies the creation of a bond throughout time that involves the flow of information, appropriate treatment and the establishment of a relationship between health professionals, coordinated by the primary care system, that guarantees continuity of treatment[27]. This study shows that some of these features are present. Continuity of care was observed in the returns for clinical follow-up by the EqSFs after appointments and/or examinations carried out in other service networks and in new appointments under the ESF for patients who were unable to obtain care in the other health facilities to which they had been referred. *With the arrival of the doctor... the patient returns, keeps on coming back to the center until he/she is stable. So we reschedule, the sevice user leaves here with an appointment schedued for the following week, you know? In this way the doctor provides continuity until the patient becomes stable.*

In contrast to the current situation, the following account mentions the doctors before the arrival of the *Mais Médicos* program doctors: *so the patients didn't come back, they were outraged. One ripped up the presciption here in the corridor.* [...] *there were days when nobody wanted to make an appointment with that doctor.*

In this respect, there was an increase in comprehensiveness in terms of desire and willingness to resolve problems, actioning the SUS[4].

Guarenteeing home visits

According to the interviewees, *home visits* also contribute towards improving *access, making patients feel comfortable, creating bonds and continuity*, particularly as a way of reaching those who need to continue their treatment and are unable to get to the health centers. *So this is a positive point, that our families, those who are unable to get to the health center, bedridden patients, get to be visited by a doctor, and where the doctor can request tests and follow-up these patients.* Home visits also provide an opportunity for health promotion and disease prevention, which are other elements of comprehensiveness. *We carry out home visits every week, which also serves to put things into the overall context*

TOGETHER with doctor (a) we are a TEAM

With respect to this dimension, the aim was to describe how and what work should be "carried out together", according to the principles of primary health care: whether meetings were planned, whether the team thinks together about problems and their solutions, or whether one of the team members took on a predominant role in decision making.

Multidisciplinary team work and thinking about and implementing resolutive and effective strategies are other elements of comprehensiveness. The way in which teams organize their work and the type of joint tasks are important indicators of comprehensiveness. The relationship with the NASF and the SUS service network are also important features of comprehensiveness.

Team work implies the integration of collective knowledge and consenus in daily practices and should not be a juxtaposition of disciplinary knowledge. One of the complaints of *nondoctor* team members prior to the *Mais Médicos* program was the lack of space to exercise functions and that doctors tended to view team work as restricted to teams of doctors[28]. There was a consensus that team work implies joint planning.

Marina Peduzzi proposes a typology of *team work* based on the concept of *integration* or *grouping of persons*[29], where integration means adopting a comprehensive approach and grouping is aligned with a fragmented approach towards acting in reality. Peduzzi suggests that integration is tantamount to intrinsic communication within work and working together.

The EqSFs' work with the *Mais Médicos* program doctors is developed *together*. It is interesting to note that a general analysis of the ideas expressed by the interviewees shows the most commonly used words were *together*, *work*, *always*, and *team* (Figure 1).

According to the interviewees, one of the elements of working together is horizontality, especially mentioning the fact that *Mais Médicos* program doctors do not treat people differently according to their profession and show *humility in relating to people* and the concept of *partnership*: *The doctor makes people feel very comforatble and is very humble, and fits in with all team members. She does not have this thing about saying health agents are different from doctors, from nurses. She treats everyone the same; we help eachother, when I have a doubt the doctor helps me, she is a very helpful person.*

Appart from suggesting that doctors work *together,* nondoctor interviewees praised doctors for supporting each member of the team, by clarifying doubts, helping to resolve work problems and working together in unity: *We have very good relatinship. Very good. Not just with me, but with the whole team. We sit down to discuss things, clarify doubts.* [...] *And, when there is a problem, I take my patient. When the doctor has a problem she comes with me. The two of us decide together.*

The interviewees spoke about their experiences with team meetings, suggesting that they resolved issues through group discussions: *Everything we do here is done in agreement, in partnership, ... we have monthly meetings to evaluate progress, to make improvements, and resolve pending issues, talk about how things are going.*

The majority of the interviewees mentioned that in these meetings all the health workers from the health center get together to plan activities, which is a necessary element of interdisciplinary team work: *We have team meetings for joint planning* [...] *in the meeting we discuss how best to work/do home visits with the doctor.*

Meetings scheduled in advance, joint planning of activities and horizontal relations between team members contribute towards multidisciplinary team working. Studies of the work undertaken by EqSFs in Brazil have shown a low level of interaction between different professions and unequal power relations[30]. According to the interviewees the *Mais Médico*s program therefore comprises a shift in approach.

Team communication, one of the key attributes for successful teamwork, also emerged in the accounts. All interviewees praised the communication between the *Mais Médicos* program doctors and other team members: *We are always together, always talking, always updating; we feel that we are united and there is effective communication*.

Some interviewees also mentioned lessons learned from the nonBrazilian doctors with respect to pimary health care, including changes to work procedures, particularly the organization of care, appointment scheduling and case-by-case spontaneous demand: *The doctors have also*

Figure 1. Cloud of the 50 most commony-used words to describe team work – interviews conducted with members of the family health teams involved in the *Mais Médicos* Program in selected municipalities throughout Brazil (2014-2015).

Source: elaborated by the authors using the data gathered from the interviews.

taught us how things should be done, things that we didn't have much idea about; So we changed appointment scheduling; the appointments are prescheduled, but there are also [...] *for emmergencies, that we leave open for spontaneous demand since people in rural areas are not always able to come in and schedule an appointment and then come back the next day.*

However, the "grouping" typology was evident in certain teams, where doctors requested health staff members as and when necessary and did not create space for discussing and problematizing tasks[29]. In one of the few cases where his happened, one of the team members stated that *everything has to be done the doctor's way* suggesting that this doctor had a limited capacity for reaching consensus on carrying out tasks, one of the fundamental pillars of team work.

Finally, it is important to note that the only negative comment about working with the *Mais Médicos* program doctors involved personal relationship issues. In this case, interviewees commented that, although there were still problems, the quality of the relationship had improved: *The quality of appointments has improved and the patients like this. The problem is that this doctor has, I don't know, a strong temperament, a strong personality. She likes to tell people what to do. I think she thinks that as she's a doctor she can tell everyone what to do.* These challenges of working in a team stem from the hegemonic medical model[31] that favors a biological perspective of health problems that is limited to the physical aspects of human beings, ignoring the interrelationship between physocological, socioeocnomic and cultural dimensions.

Experiences with NASFs

The majority of interviewees mentioned that their municipality either did not have a NASF or that it was currently being implemented and that this presented an obstacle to integration with support staff. Gastão Campos describes the NASFs as support for ESF teams[32]. Eugênio Villaça Mendes suggests that, despite positive results, the support provided by the NASFs remains insufficient to ensure positive health outcomes in relation to chronic cases, principally among multidisciplinary teams[33].

In line with the literature, many of those who stated that there was a NASF in their municipality suggested that integratoin is a result of *working together*, be it through group activities, community actions or health promotion in schools: *the doctors interact effectively and work together. I think that is important.* This integration is facilitated by the fact that team members share the same physical environment. *I think that the support provide by the NASFs is more frequent. Because, before, when a patient was referred to a nutricionist or pschologist, they did not see the patient here in the center* [...]. *He/she was referred to there. But not now, now they see the patient here at the center. They are always together with the doctor, with the Mais Médicos.*

Comprehensiveness is reflected in the level of integration between the health teams and NASFs, given that they favor interdisciplinarity and intersectoral actions, respectively. Efforts to guard against fragmentation are also defined as a driving force towards comprehensiveness[7].

Conclusion

The following features of comprehensiveness were evident in the daily practices of the family health teams after the inclusion of doctors from the *Mais Médicos* Program: *increase in accessibility* due to an increase in the supply of services and greater willingness to meet needs; improvements in *making patients feel comfortable, establishing bonds with and respect to service users* because these values go beyond the physical aspects of health and enhance comprehensiveness as a feature of good medicine; *willingness to resolve problems and continuity of care* because the program has strengthened coordination within the SUS network and primary health care's pivotal role in the organization of the system; *Guarenteeing home visits* because care delivery was adapted to the population's health needs, providing the opportunity to develop actions directed at disease prevention and health promotion; and the *integration of health teams within health centers and with the NASFs* favoring interdisciplinarity and intersectoral actions and understanding of the health care process.

It can therefore be concluded that, from the perspective of the members of the family health teams, the *Mais Médicos* Program contibuted towards enhancing comprehensiveness in the daily practices of the ESF teams, thus leading to improvements in primary health care delivery.

Collaborations

Y Comes participated in data collection, analysis, interpretation and discussion, article conception and design, and the critical review of this article. ICHC Barreto, VM Pessoa, JS Trindade, CAM Arruda and D Dewes participated in data collection and interpretation and in drafting and critically reviewing this article. HE Shimizu participated in drafting and critically reviewing this article. LMP Santos elababorated the project, coordenated the research, and participated in data collection and in the critical review of this article. All authors reviewed and approved the final version of this manuscript.

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Article submitted 04/03/2016
Approved 08/06/2016
Final version submitted 10/06/2016