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National EPAs of Family Medicine in Brazil

EPAs nacionais de Medicina de Família e Comunidade no Brasil

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ABSTRACT

Introduction: The development and validation of the National EPAs in Family Medicine (FM) serve as a strategy to enhance the quality of postgraduate training by identifying units of professional practice that clearly represent the specialty's core identity and guide gradual entrustment decisions throughout residents' training trajectories. This initiative addresses the complexity of Primary Health Care (PHC) and in-service training, both characterized by diverse curricula and difficulties in directly assessing clinical performance.

Objective: To describe the process of developing and validating the FM EPAs, presenting the resulting panel and its implications.

Method: The process adhered to international guidelines for EPAs development and validation. It involved creating a steering core group; using the nominal group technique for initial idea generation; refining the technical and descriptive aspects; evaluating the structure with the EQualRubric; and validating through the Delphi method, including calculating content validity indices, intraclass correlation coefficients, and analyzing qualitative data. All phases maintained regional diversity, professional representation, and methodological rigor.

Results: The initial stage produced 26 EPAs, later refined to 15 after technical review. The EQual Rubric analysis identified structural aspects needing improvement, which were incorporated before the next phase. In the Delphi study, with 45 participants, 14 EPAs reached consensus in the first round, while the remaining EPA was revised and validated in the second. Validity and reliability indicators demonstrated strong structural integrity, leading to a national panel of units of professional practice for the specialty.

Conclusion: The national FM EPAs represent a strategic advancement in training quality by enhancing curricular coherence, refining assessment processes, and strengthening educational governance. They serve as a foundational tool for aligning medical residency training with current PHC demands and the ethical and social commitments of the specialty.

Keywords: competency-based education; family practice; medical residency.

RESUMO

Introdução: *A elaboração e validação das EPAs nacionais de Medicina de Família e Comunidade (MFC) são estratégias para a qualidade na residência médica, ao definirem unidades de prática profissional que expressam, operacionalmente, o escopo identitário da especialidade e orientam decisões progressivas de atribuição de confiança ao longo da trajetória formativa do residente. Essa iniciativa responde à complexidade da atenção primária à saúde (APS) e à própria formação em serviço, em sua heterogeneidade curricular e pelas dificuldades de avaliação direta do desempenho clínico.*

Objetivo: *Este estudo teve como objetivo descrever o processo de elaboração e validação das EPAs de MFC, apresentando o painel resultante e suas implicações.*

Método: *O processo seguiu as recomendações internacionais para construção e validação de EPAs. Abrangeu a constituição de um grupo gestor, a aplicação da técnica de grupo nominal para geração inicial, o refinamento técnico-descritivo, a avaliação estrutural pelo EQual Rubric e a validação por método Delphi, com cálculo dos índices de validade de conteúdo, coeficientes de correlação intraclasse e análise de dados qualitativos. Todas as etapas asseguraram diversidade regional, representatividade profissional e rigor metodológico.*

Resultado: *A etapa inicial produziu 26 EPAs, posteriormente refinadas para 15 após revisão técnica. A análise pelo EQual Rubric identificou pontos estruturais a serem aprimorados, que foram incorporados antes da etapa subsequente. No Delphi, com 45 participantes, 14 EPAs alcançaram consenso na primeira rodada, enquanto a EPA remanescente foi ajustada e validada na segunda rodada. Os indicadores de validade e confiabilidade demonstraram robustez estrutural, o que resultou em um painel nacional de unidades de prática profissional da especialidade.*

Conclusão: *As EPAs nacionais de MFC constituem um avanço estratégico para a qualidade da formação, ao fortalecerem a coerência curricular, aprimorarem os processos avaliativos e consolidarem a governança educacional. Tratam-se de um instrumento estruturante para alinhar a residência médica às demandas contemporâneas da APS e aos compromissos éticos e sociais da especialidade.*

Palavras-chave: *Educação Baseada em Competências; Medicina de Família e Comunidade; Residência Médica.*

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INTRODUCTION

Brazilian Primary Health Care (PHC) constitutes a scenario of increasing epidemiological, demographic, and organizational complexity, which demands professionals able to manage, in an integrated manner, the multiple population needs and dynamics[1, 2]. Family Medicine (FM), as a medical specialty, plays a central role in providing problem-solving care, incorporating the essential attributes of PHC[3]. Its core action is the provision and coordination of continuous, inclusive, and comprehensive care for people, families, and communities, distinguished by its person-centered approach across all age groups and life cycles[4,5].

Medical residency (MR), as part of a continuum that sustains safe professional progression, is articulated with previous training and, in a decisive and irreplaceable way, offers a supervised training environment that enables the consolidation of the competencies necessary for the training of specialist physicians[6]. It is precisely in this articulation between training, supervised practice, and increasing performance in the service and in the system that the quality of the specialized workforce is ensured, an essential condition for responding consistently and responsibly to contemporary health challenges[7, 8].

In the case of FM, specialized training assumes strategic relevance due to its direct relationship with the implementation of the organizational principles and guidelines of PHC[9, 10]. Although the specialty has experienced a wide expansion of its training capacity in Brazil, structural challenges persist in MR[11] programs, such as curricular heterogeneity, the fragility of systematic supervision mechanisms and evaluation processes[12]. Such challenges compromise the consistency of certification and highlight the need to qualify and develop guiding resources to ensure the effectiveness of competency-based education, sustaining training trajectories consistent with the contemporary demands of PHC and the Brazilian Unified Health System (SUS, Sistema Único de Saúde) [13, 14].

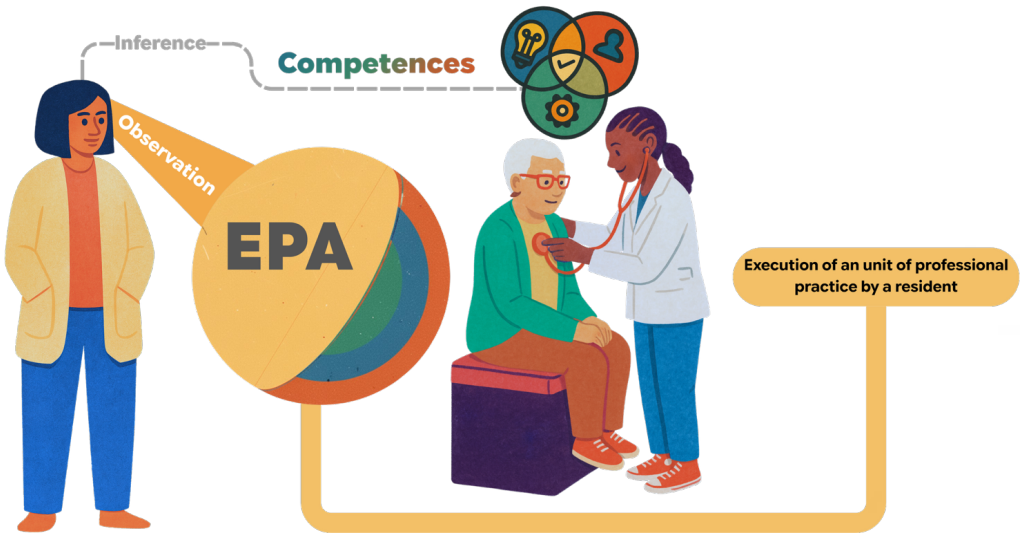
Entrustable Professional Activities (EPAs) correspond to essential and routine activities performed by specialized and competent professionals in their area of expertise[15]. In the context of competency-based education, an EPA constitutes a unit of professional practice: an observable, measurable activity whose performance can only be entrusted to adequately trained and evaluated professionals[16]. Although the concept of "unit of professional practice" may, at first sight, seem abstract, it becomes more comprehensible when understood as a descriptor of work: units are tasks that, when enunciated, immediately refer to the professional identity and scope of action of a given specialist, expressing, in a concrete and operational way, the nature of their practice[17].

Competencies, in turn, refer to what the learner mobilizes and develops throughout the education (knowledge, skills, and attitudes) and characterize personal attributes that underlie their performance[18]. It is, therefore, essential to distinguish: one does not "acquire" an EPA; they are able to perfom it autonomously due to the effectively acquired competencies[19].

EPAs specify what must be accomplished, while competencies describe what the learner mobilizes to perform them[20]. Observing an EPA performed by an apprentice allows us to infer the acquisition of the competencies related to it (Figure 1).

The competency matrix for MR programs in FM, defined by the National Commission of Medical Residency (CNRM, Comissão Nacional de Residência Médica), lists 390 competencies distributed over the two years of training organized in multiple domains[21]. Although comprehensive and informative, its extension and markedly analytical character[22]

Figure 1. The relationship between EPAs and competencies.



Source: The authors

introduce relevant complexities and risks to the assessment and educational process: difficulties in prioritization and hierarchization, fragmentation of the components to be observed, and restrictions on assessment feasibility through direct observation in clinical practice[23]. Consequently, the ability to verify the residents' readiness to perform the essential professional practice units that define the FM specialist is limited.

In this context, the Brazilian Society of Family Medicine (SBMFC, Sociedade Brasileira de Medicina de Família e Comunidade), the national representative entity for the specialty, promoted the creation and validation of the National EPAs in FM[24]. This article details the methodological path and process adopted, presenting the developed EPAs and discussing their perspectives and implications for the educational qualification of MR programs in FM, in dialogue with the specialty's social commitment and its structuring influence on Brazilian PHC and the SUS[10].

METHOD

The development and validation of the National EPAs in Family Medicine followed international recommendations that emphasize systematic processes of construction, content analysis, consensus, and validity evidence[25, 26]. The process, structured in successive and interdependent stages, began in October 2023 and was completed in March 2025.

The SBMFC established a management core group (CG) for the process, with support and academic guidance from an educator with expertise in EPAs. To ensure the diversity of perspectives, a public call was issued to assemble a group of specialists with degrees in FM and with educational or healthcare experience in the SUS. It sought to ensure territorial, institutional, and gender representativeness, minimize technical-institutional biases, and expand the panel's legitimacy. A Nominal Group (NG) was formed for the first stage of creation.

In a face-to-face session, facilitated by the invited educator, the nominal group technique[27] was applied, a structured method of discussion and consensus-building, resulting in a preliminary panel of EPAs. From this preliminary panel, the first refinement cycle began, conducted by the CG, preserving the conceptual core of the created EPAs, improving and expanding the descriptive elements to meet the structural, conceptual and operational criteria recommended by the literature[15, 25]. Each member of the CG produced an individual review report, the consolidation of which supported the definitive changes to the preliminary panel, which were collectively deliberated. Next, the CG drew up the list of tasks and limitations for each EPA from the refined panel.

The refined panel was submitted to evaluation by the NG through the EQualRubric[28], a validated instrument for the analysis of the structural quality of EPAs, consisting of 14 criteria distributed in three domains: delimitation and measurement of professional practice, essentiality and reliability of the activity, and curricular integration in the educational program. Scores were generated by criterion, aggregated scores by domain, and a global mean score by EPA, all of which range from 0 to 5 points. For interpretation, the mean reference cutscore of 4.07 was adopted, establishing the cutoff point at which an EPA is considered adequately structured. The use of EQual Rubric allowed us to identify, with greater precision, the EPAs and which of their aspects required adjustments before advancing to the subsequent methodological stage.

The post-EQualRubric reviewed panel proceeded to apply the electronic version of the Delphi method[29, 30]. The study questionnaire initially contained items of sociodemographic characterization and, for each EPA, three questions with a numerical scale of agreement related to the structural dimensions that determine validity[15, 31]: comprehensiveness of the EPA title, tasks, and limitations; prevalence of the EPA in clinical practice; essentiality for FM work. Additionally, for each EPA, an optional open field was included for comments.

Data analysis used descriptive statistics for numerical variables and frequency tables for categorical variables. For the agreement items, the Content Validity Index (CVI) for the three evaluated dimensions, the mean CVI (S-CVI/AVE), and the CVI for universal agreement (S-CVI/UA) were calculated. When using a Likert scale, the CVI corresponded to the proportion of responses located at the upper levels of the scale (4 or 5). The mean CVI was obtained by averaging the dimensional CVI, serving as a global measure of the validity of each EPA. The CVI for universal agreement represents the proportion of dimensions that received the maximum score from all experts, constituting a stricter indicator of consensus. This set of metrics allowed us to estimate the structural robustness of the EPAs, identify convergence patterns, and guide the need for new iterations in the process. The answers to the open fields were organized with the support of an artificial intelligence tool, used exclusively for linguistic standardization, thematic categorization, and sequential reorganization of the content, while fully preserving the original meaning for later analysis by the CG.

The research method did not define a fixed number of rounds, establishing as a criterion for the end of the Delphi study the achievement of an S-CVI/AE higher than 80%, a parameter widely accepted in the literature as an adequate content validity threshold[32]. As an additional measure of inter-rater reliability, the intraclass correlation coefficient (ICC) was used by the model (2,1), allowing the decomposition of total variability into components attributable to differences between EPAs and residual variability, which allows estimating the stability of

the judgments attributed beyond chance[33]. Statistical analyses were performed using SAS software, version 9.4 (SAS Institute Inc., USA), adopting a significance level of $p<0.05$.

Data collection and analysis followed Resolution N. 466/12 of the National Health Council, within the scope of the research project "National Validation of EPAs (Entrustable Professional Activities) for Medical Residency in Family Medicine", approved by the Research Ethics Committee of the School of Medical Sciences at the University of Campinas (CAAE N. 82395724.2.0000.5404). All participants were previously informed about the objectives of the study, signed an Informed Consent Form and had their data anonymized to ensure privacy and confidentiality.

RESULTS

The development of the EPAs included the constitution of a CG — authors — and an NG, formed by 13 specialists, selected to ensure gender parity and representativeness of the Brazilian macro-regions. Using the nominal group technique, a preliminary panel with 26 EPAs was produced. After the first refinement cycle by the CG, a panel with 15 EPAs was consolidated, each one accompanied by its tasks and respective limitations. To those sent for the NG evaluation, the EQual Rubric scores allowed them to identify, in a structured way, aspects that still required refinement (Table 1).

The sample of the Delphi study consisted of 45 participants. The age distribution showed that 40% were between 25 and 35 years old, 31% between 36 and 45 years old, 24% between 46 and 55 years old and 4% between 56 and 65 years old. The length of time working in PHC ranged from 2 to 35 years (mean of 12.9 years). Regarding ethnic-racial self-declaration, 57.8% identified themselves as white, 28.9% as "pardo", 8.9% as black, and 4.4% as indigenous. Balance was observed in the gender distribution, with 51% of cisgender women and 49% of cisgender men. All Brazilian macro-regions were represented, with a greater concentration in the Southeast and South, accompanied by a consistent participation of the Northeast, North and Midwest regions. Among the federation units, Rio de Janeiro (17.8%), São Paulo (11.1%), Minas Gerais (8.9%) and Rio Grande do Sul (8.9%) stood out, in addition to Pernambuco, Pará, Bahia, the Federal District and Rio Grande do Norte (6.7% each).

Two rounds were conducted in the Delphi Study, with a dropout rate of 17.8% relative to the initial number of participants. In the first round, 14 of the 15 EPAs achieved the required level of consensus. EPA 15 did not reach the minimum score and was reviewed based on statistical analysis and qualitative comments; After adjustments, it reached consensus in the second round. The inter-rater reliability analysis showed statistically significantly greater agreement in the essentiality dimension (ICC = 0.8667), followed by the prevalence dimension (ICC = 0.7902). The clarity dimension showed less interpretative uniformity (ICC = 0.4367), indicating greater variability among participants. Table 2 shows the calculated final CVIs, which supported the consensus decision for each EPA.

Table 1. EQual Rubric Scores.

	Delimitation and Measurement	Essentiality and Reliability	Curricular Integration	Global EQual Rubric Score
EPA 1	3.3	3.75	4.35	3.92
EPA 2	3.61	4.22	4.26	3.97
EPA 3	3.85	4.26	4.36	4.11
EPA 4	3.78	4.29	4.22	4.05
EPA 5	4.4	4.51	4.56	4.48
EPA 6	4.45	4.6	4.6	4.53
EPA 7	4.9	4.17	4.82	4.67
EPA 8	4.73	4.37	4.6	4.59
EPA 9	4.15	4.1	4.2	4.15
EPA 10	4.5	4.55	4.7	4.57
EPA 11	4.15	4.15	4.42	4.22
EPA 12	4.55	4.7	4.67	4.62
EPA 13	4.31	4.45	4.47	4.4
EPA 14	3.98	4.2	4.42	4.17
EPA 15	3.58	3.65	4.03	3.78

Source: The authors

Chart 1 lists the titles of the National EPAs in FM — units of professional practice that the resident must be able to perform autonomously at the end of training — along with their descriptions, which summarize the scope, purpose, and relevance. The complete panel includes: each EPA's list of essential tasks, which operationalizes observable criteria for trust assignment decisions; limitations, which delimit the scope of the unit of professional practice and prevent overlaps; and correlation with the domains of the CNRM competency matrix, guiding the residency programs in identifying the knowledge, skills, and attitudes required for the performance of the EPA. All material is available in open access, in digital book format[34], in the institutional domains of the SBMFC.

Table 2. Content Validity Indexes: National EPAs in FM.

	CVI-C	CVI-P	CVI-E	S-CVI/AVE	S-CVI/UA
EPA 1	80%	100%	100%	93.33%	74.07%
EPA 2	93.3%	93.3%	97.7%	94.76%	74.97%
EPA 3	91.1%	93.3%	97.7%	93.33%	79.27%
EPA 4	82.2%	97.7%	97.8%	92.56%	79.27%
EPA 5	86.6%	97.7%	97.8%	94.03%	86.57%
EPA 6	91.2%	100%	100%	97.06%	88.16%
EPA 7	91.2%	93.3%	93.3%	92.6%	79.26%
EPA 8	95.5%	100%	100%	98.5%	84.43%
EPA 9	88.9%	97.7%	95.6%	94.06%	76.3%
EPA 10	84.5%	100%	100%	94.84%	84.46%
EPA 11	95.6%	95.6%	97.8%	96.3%	88.16%
EPA 12	95.6%	93.4%	95.5%	94.83%	85.93%
EPA 13	91.1%	91.1%	97.8%	93.34%	82.2%
EPA 14	95.6%	97.8%	100%	97.8%	88.9%
EPA 15	94.6%	78.3%	72.9%	81.93%	59.83%

Source: The authors

Chart 1. National EPAs in FM.

EPA 1	Providing comprehensive care across all ages and and life cycles	Entrusts the resident to provide comprehensive care across all ages and life cycles, conducting consultations, managing prevalent problems, promoting preventive actions, identifying situations of violence, and advocating for rights, ensuring comprehensive, safe, and person-centered care.
EPA 2	Proving care for individuals of of ethnicity, race, or culture similar to or distinct from one's own	Entrusts the resident to provide care for individuals of different ethnicities, races, or cultures, considering diversity, assessing the impacts of racism on health, documenting cultural aspects, articulating intersectoral resources, and promoting anti-racist education, ensuring equitable and culturally sensitive care
EPA 3	Providing care for LGBTQIA+ individuals	Entrusts the resident to provide care for LGBTQIAPN+ individuals, addressing sexuality, managing specific conditions, identifying situations of violence, supporting body modification processes, and engaging support networks, ensuring inclusive care free from discrimination.
EPA 4	Providing care for individuals in situations of vulnerability	Entrusts the resident to provide care for individuals in situations of vulnerability, managing health problems in specific contexts, providing care to victims of violence, performing notifications, and articulating the intersectoral network, ensuring accessible, safe, and individually appropriate care.

Continue...

Chart 1. Continuation.

EPA 5	Coordinating care based on the person's needs	Entrusts the resident to coordinate care according to people's needs, organizing clinical records, using management tools, supporting care transitions, and managing network resources, ensuring continuity, efficiency, and equity.
EPA 6	Providing home-based care	Entrusts the resident to provide home-based care, identifying eligibility, stratifying risk, coordinating teams, conducting visits and consultations, supporting support networks, and instructing caregivers, ensuring comprehensive, safe, and personalized care.
EPA 7	Performing outpatient procedures	Entrusts the resident to perform outpatient procedures, indicating and executing interventions, organizing the setting, obtaining consent, providing post-procedure follow-up, and managing complications, ensuring quality, safety, and respect for autonomy.
EPA 8	Providing initial care in urgent and emergency situations	Entrusts the resident to conduct initial care for urgencies and emergencies, organizing resources, performing risk classification, providing basic life support, and referring appropriately, ensuring prompt, effective, and coordinated responses.
EPA 9	Facilitating educational processes in Family Medicine for peers and other learners	Entrusts the resident to facilitate educational processes in Family Medicine, seeking scientific evidence, designing educational strategies, applying learner-centered methodologies, and fostering qualified teaching environments, ensuring continuous and collaborative learning.
EPA 10	Providing care for individuals affected by mental disorders	Entrusts the resident to provide care for individuals with mental disorders, performing clinical examinations, formulating differential diagnoses, using psychotropic medications and non-pharmacological interventions, managing psychiatric emergencies, and articulating the care network, ensuring comprehensive, safe, and evidence-based care.
EPA 11	Organizing health work processes	Entrusts the resident to organize health work processes, developing epidemiological surveillance, managing care workflows, strengthening interprofessional work, and promoting continuing education, ensuring efficiency, collaboration, and quality of care.
EPA 12	Applying the family approach in the care of individuals and their families	Entrusts the resident to apply the family approach, using diagnostic and interventional tools, conducting family interviews and conferences, and articulating care within the context of relationships, ensuring care centered on the family system.
EPA 13	Applying the community approach in the care of individuals, families, and communities	Entrusts the resident to apply the community approach, performing territorialization, situational diagnosis, mobilization of local resources, popular education, and group facilitation, ensuring care aligned with collective needs.
EPA 14	Promoting access and continuity of care	Entrusts the resident to promote access and continuity of care, reducing barriers to care, using technologies to expand access, stratifying risk, organizing schedules, and performing active outreach, ensuring equity and resolutiveness.
EPA 15	Promoting planetary health in one's context	Entrusts the resident to promote planetary health, assessing socio-ecological impacts, managing conditions related to environmental crises, planning mitigation actions, and participating in intersectoral initiatives, ensuring commitment to sustainability and global health

Source: The authors

DISCUSSION

The development of the National EPAs in Family Medicine (FM) is a milestone for the specialty in Brazil[24, 34]. The process, conducted with methodological and scientific rigor, ensured internal consistency, content validity, and professional consensus[25, 26, 32, 35]. In addition, it aligns with the recommendations of Ten Cate et al.[15, 25, 26], who emphasize that the development of EPAs should preferably occur at the national level or within specialty societies to ensure conceptual unity, representativeness, and legitimacy, although local initiatives and independent studies can offer relevant complementary contributions[36-39].

A decade after the publication of the first curricular framework for the specialty[40], profound epidemiological, social, and technological transformations have redefined the role of Primary Health Care (PHC) and expanded its problem-solving capacity[5, 10]. In this scenario, it is essential to update the training framework, qualify the evaluation processes, and align FM with the global agendas of sustainable development, universal coverage, and strengthening of health systems[41-43].

The EPAs reflect this structuring position by organizing activities that express the core identity of the specialty and by describing, in an operational way, the responsibilities that characterize the full performance of the family physician[44, 45]. By articulating individuals, families, territories, health systems, and social and environmental determinants, the EPAs translate a care model that is consistent with the complexity of the population's needs.

The resulting set incorporates contemporary dimensions that expand and tension the specialty's training scope, reinforcing the demand for professionals capable of working in scenarios of increasing multidimensional complexity[46]. It is explicit that qualified clinical care is inseparable from social accountability, anti-racist commitment, the promotion of inclusion, diversity, and equity, as well as the incorporation of the planetary health perspective[47-49]. These commitments are made in the care of individuals and families, at home, in the community, and in the intersectoral and interinstitutional actions that structure the practice of FM —a practice that, ultimately, constitutes an expression of social justice in access to health[1].

At the same time, the EPAs bring FM closer to international trends that define standards of professional practice oriented to safety, quality, and educational predictability[50, 51], preserving the specificities and needs of the Brazilian context[52].

By complementing the national competency matrix, the EPAs become a direct, observable instrument aligned with the clinical reasoning in practice, guiding decisions about the resident's progressive autonomy[53]. However, its transformative potential goes beyond the assessment function. The adoption of EPAs acts as an inducer of educational reorganization by allowing the detailed mapping of the curriculum and its formative agents, making visible congruences and incongruences between the educational offer and the resident's effective experience[12, 54]. This process guides adjustments to the matrix of educational scenarios, strengthens assessment systems through triangulation of evidence, and identifies needs for the development of educators, both in the pedagogical dimensions — competency-based assessment, entrustment decisions, and quality in feedback practices — and in the clinical dimension, ensuring that supervisors can reflect contemporary patterns of FM.

Finally, by establishing national parameters for educational quality, the EPAs also fulfill a political function, especially in a context marked by policies to expand training, which have historically been little accompanied by robust quality assurance mechanisms[14, 56, 57]. Thus, the EPAs not only guide the assessment of individual competence but also serve as an instrument of educational governance and as a structuring axis for the strengthening of FM and PHC in the country[10].

CONCLUSION

The development of the National EPAs in Family Medicine is an unequivocal affirmation of the specialty's — and the SBMFC's — commitment to educational quality. The transformative potential of this framework stems precisely from its affirmative force: by making explicit the units of professional practice that define the full exercise of FM, with their ethical, technical, and social dimensions, it renews the debate on training and strengthens the governance of educational processes in the country. In doing so, they reaffirm the need for valorization, structuring, and continuous investments in medical residency, the central and sustainable path for training specialists capable of responding, with competence, to the real needs of the population and health systems. The EPAs, therefore, open a horizon of permanent responsibility and demand: for quality, coherence, and commitment to a truly transformative medical education for Brazilian health.

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AUTHORS' CONTRIBUTIONS

Ugo Caramori: Conceptualization; Data curation; Formal analysis; Research; Methodology; Project administration; Resources; Validation; Visualization; Writing – original draft; Writing – review and editing. Andrea Taborda Ribas da Cunha: Conceptualization; Formal analysis; Funding; Research; Methodology; Project administration; Resources; Validation;

Visualization; Writing – review and editing. Leonardo de Andrade Rodrigues Brito: Data curation; Formal analysis; Research; Methodology; Resources; Validation; Writing – review and editing. Rafaela Alves Pacheco – Conceptualization; Research; Methodology; Validation; Writing – review and editing. Rafaela Aprato Menezes – Investigation; Methodology; Validation; Writing – review and editing. Cassandra Renault Pisco – Conceptualization; Research; Methodology; Validation; Writing – review and editing. Fernanda Lazzari Freitas – Investigation; Methodology; Validation; Writing – review and editing. Mauro Magaldi Lins – Investigation; Methodology; Validation; Writing – review and editing. Lívia Hinz Caliço – Investigation; Methodology; Validation; Writing – review and editing. Zeliete Linhares Leite Zambom – Conceptualization; Funding; Validation; Writing – review and editing.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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DECLARATION OF DATA AVAILABILITY

Research data are only available upon request.

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