

Implementation of Brazil's National Policy on Complementary and Integrative Practices: strengths and weaknesses

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Abstract *This narrative review examines the literature on complementary and integrative practices (CIPs) and their incorporation into Brazil's national health system (Sistema Único de Saúde – SUS) in an attempt to understand the strengths and weaknesses of the implementation of the National Policy on Complementary and Integrative Practices in the SUS (PNPIC, acronym in Portuguese). A search was conducted of the MEDLINE, LILACS, and SciELO databases, resulting in final sample of 25 articles. Our analysis identified five key themes in the literature related to the strengths and weaknesses of policy implementation: 1) Professional training in CIPs in the SUS; 2) structuring the provision of CIPs, access, and health promotion; 3) knowledge, access, and acceptance of service users in relation to CIPs; 4) knowledge of SUS professional staff and managers in relation to the PNPIC; and 5) scope and monitoring and evaluation of the PNPIC. In consonance with the conclusions of the PNPIC management reports, the findings provide a deeper insight into policy implementation problems and reinforce the need to empower the actors involved in this process to tackle these challenges.*

Key words *Review, Complementary Therapies, Unified Health System, Public Policy*

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Introduction

Against the backdrop of the epidemiological transition witnessed in the twentieth century, chronic and degenerative diseases have emerged as the leading cause of morbidity and mortality globally, prompting a shift in the public health paradigm under which primary healthcare (PHC) and health prevention and promotion are viewed as priorities¹.

In the 1970s, other determinants of health (biological, environmental, and lifestyle factors) gained prominence, raising questions about the effectiveness of the biomedical model of healthcare. This situation, combined with the high cost of biomedical procedures, spurred a growing interest in therapies that lie outside the bounds of scientific medicine.

Complementary and Integrative Practices (CIPs) give precedence to therapy over diagnosis and are underpinned by theories that focus on environmental and behavioral determinants of health, making them interesting strategies for tackling new healthcare challenges.

In view of the above, in 1970, the World Health Organization (WHO) launched its Traditional Medicine Program, aimed at developing public policy in the area. In 2002, it published the “WHO Traditional Medicine Strategy”², geared towards supporting national research and training programs, defining technical guidelines and standards, facilitating information exchange, and incorporating Traditional Medicine/Complementary and Alternative Medicine (TM/CAM) into national healthcare systems.

In view of the demands highlighted during Brazil’s national health conferences and the WHO recommendations on TM/CAM, in 2006, the Ministry of Health issued the following policies governing the incorporation of CIPs in the SUS (*Sistema Único de Saúde*, Brazil’s national healthcare system): the “National Policy on Medicinal Plants”³, and the “National Policy on Complementary and Integrative Practices in the SUS” (PNPIC, acronym in Portuguese)⁴.

According to the PNPIC, the incorporation of CIPs into the healthcare system is warranted by the principle of comprehensiveness. The policy’s main purpose was therefore to foster increased understanding and support for the CIPs already adopted in public health services at the time and promote their incorporation into the public health system (with emphasis on PHC services) thus encouraging natural mechanisms of health prevention, recuperation, and promotion⁴.

Two years after the PNPIC came into force, the Ministry of Health undertook an assessment of the knowledge, institutionalization, and provision of CIPs across Brazil⁵. This study identified the following immediate strategic challenges for the implementation of the policy: 1) training and development of an adequate number of SUS staff; 2) monitoring and evaluation; 3) adequate provision of supplies and materials (homeopathic medicines and phytomedicines, needles for TCM/acupuncture); and 4) research into CIPs, expanding the knowledge-base in line with SUS needs and guidelines.

In 2011, the National Office for the Coordination of Complementary and Integrative Practices published its 2006-2010 Management Report⁶. The report provides a panorama of the implementation of the PNPIC in PHC services. The main advances highlighted by the report were the development of norms and standards and institutionalization of experiences with CIPs in line with the guidelines set out in the WHO TMS. In terms of opportunities, the report highlighted the creation of the Family Health Support Center (FHSC), which helps promote the integration of homeopathic practitioners, acupuncturists, and other allopathic medicine professionals into primary care services. The report revisits the challenges highlighted by the previous assessment and identifies new challenges, such as the structuring of complementary and integrative care in the public health system and development/revamping of specific legislation directed at services provided on the SUS.

In 2017, eleven years after the creation of the PNPIC, the Ministry of Health issued Ministerial Order 849/2017⁷, expanding the range of procedures offered by the SUS under the policy, including meditation, art therapy, music therapy, naturopathic treatments, osteopathic treatments, chiropractic treatments, and reiki. Community therapy, circle dance/biodanza, yoga, massage/self-massage workshops, auricular therapy, massage/sootherapy, and thermal treatment/crenotherapy were included in April 2016. Data from the National Program for Improving Primary Care Access and Quality (PMAQ-AB, acronym in Portuguese) show that these procedures were offered by many local health authorities in Brazil.

In 2018, during the first International Congress of Complementary and Integrative Medicine and Public Health, the Ministry of Health announced the inclusion of a further 10 practices via Ministerial Order No. 702/2018⁸: aromatherapy, apitherapy, bioenergetics, family constella-

tion, chromotherapy, geotherapy, hypnotherapy, laying on of hands, ozone therapy, and flower therapy. Anthroposophic medicine and crenotherapy, included in 2016 on an observational basis, were included on a permanent basis in 2018.

A decade after the creation of the PNPIC, the following question arises: what does the literature on CIPs in the SUS reveal in relation to the implementation of this policy?

The aim of this study was to review and analyze articles addressing this topic to identify key themes addressed by the literature and the main strengths and weaknesses of the implementation of the PNPIC.

Methods

According to Rother⁹, a narrative literature review is a method for describing and discussing the current state of knowledge about a topic of study from a theoretical or contextual point of view.

Unlike systematic reviews, the narrative review uses broad questions to conduct a critical qualitative analysis of the literature with a view to updating the reader on a scientifically relevant theme, providing new insights and contributing to the discussion and understanding of the topic⁹.

Data was collected between July and December 2016 using the Medline, Lilacs, and Scielo databases and the following descriptors: *Medicina Integrativa* (Integrative Medicine and synonymous descriptors); and *Sistema Único de Saúde*.

The search yielded 222 results (198 from Lilacs, 4 from Medline, and 20 from Scielo). Articles were selected by reading the titles and abstracts and applying the following inclusion criteria: complete available articles published in Portuguese, English, or Spanish between 2006 and 2016 (period of ten years since the creation of the policy); articles about qualitative and/or quantitative studies involving actors or potential actors in the SUS (professionals, service users, managers, and students in the area of health).

Given that narrative reviews do not seek to exhaust sources, the number of articles that met the inclusion criteria (excluding communications, editorials, interviews, literature reviews, theses, dissertations, and duplicate articles) was considered sufficient.

The final sample consisted of 25 articles. After article selection (Figure 1) the articles were read in their entirety and a critical analysis was

conducted. The narrative review was organized into five key themes discussed by the literature drawing on theoretical literature on CIPs in the SUS and comprehensiveness.

Results and Discussion

Table 1 summarizes the key themes that emerged from the analysis and demonstrates the main strengths and weaknesses of the implementation of the PNPIC.

Professional training in CIPs in the SUS

The first set of studies that addressed this theme¹⁰⁻¹⁴ highlight that SUS staff are underprepared when it comes to CIPs and a lack of training in this area at graduate and postgraduate level and in continuing education programs. The findings of these studies reiterate the conclusions of the last two PNPIC management reports^{5,6}, stressing that professional training is one of the key implementation challenges.

Another two articles^{15,16} point to a lack of follow-up on the part of health professionals in relation to the use of medicinal plants by service users. It is known that herbal medicines based on traditional knowledge have been used for a long time without posing major health risks. However, given that the improper use of plants may cause adverse effects related to overdose, the use of plants of dubious origin, and prescription errors¹⁷, follow-up of use of medicinal plants in patients with more serious diseases is desirable.

Moreover, lack of knowledge of CIPs among health professionals may also give rise to misconceptions about therapies, resulting in problems in doctor-patient relations and with colleagues who are allopathic practitioners¹⁸.

However, it is interesting to note that some studies show that lack of professional training in CIPs may be accompanied by personal use of CIPs by SUS professionals^{10-13,16,19}, suggesting that these professionals are potentially interested in seeking the necessary skills and knowledge to incorporate these practices into their work.

Despite the PNPIC, apparently low levels of training in the area, and the potential interest of health professionals in seeking skills and knowledge, the provision of CIP training courses tailored to the needs of the SUS remains incipient in Brazil^{20,21}.

In general, CIP training in Brazil is provided by the private sector via postgraduate courses

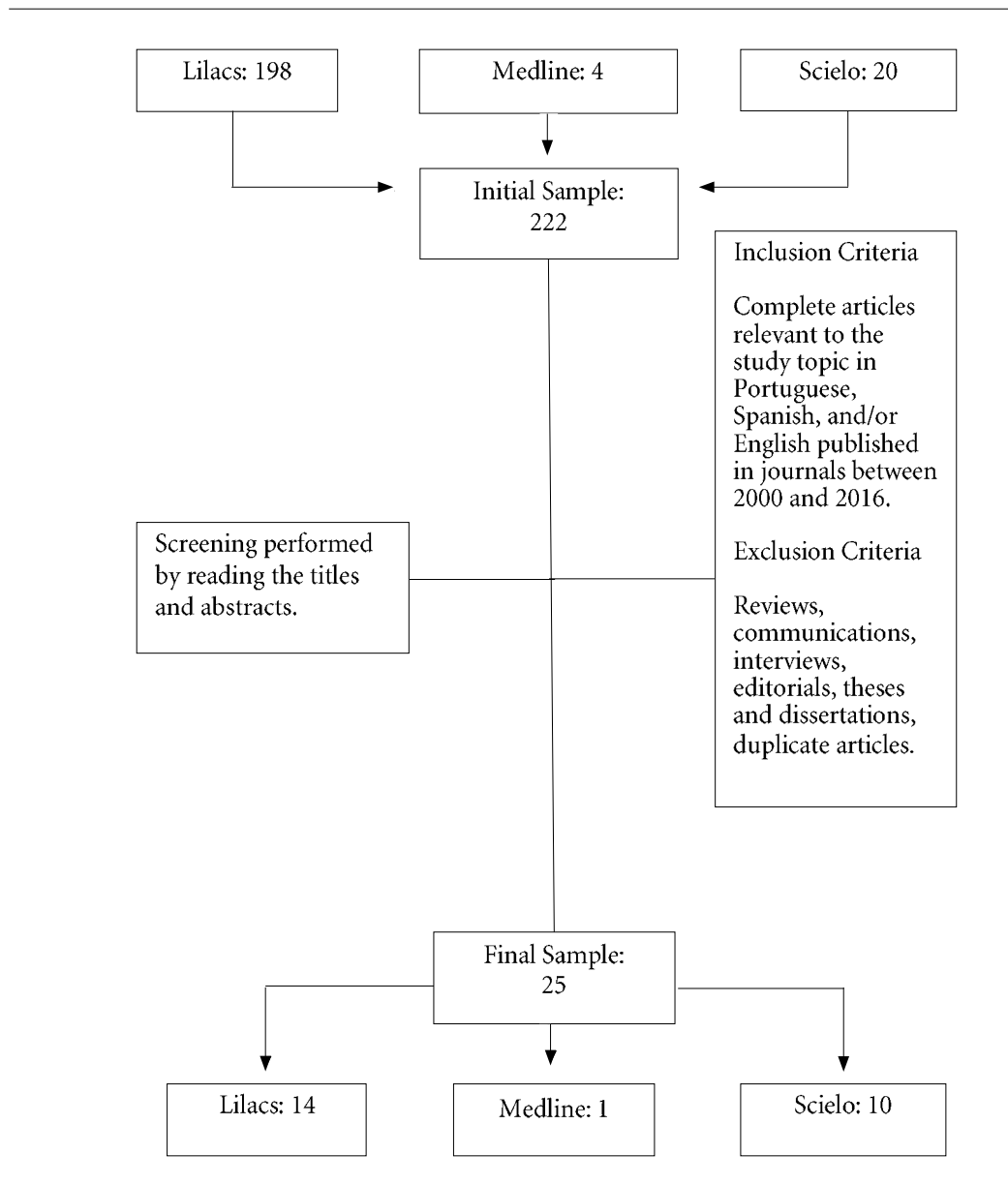


Figure 1. Article selection.

with a student workload of around 1,200 hours, providing the professional with a specialist qualification. On undergraduate courses, CIP training is generally limited to optional modules (60 classroom hours and 4 credits) in a few universities mainly taught voluntarily by specialists²².

In a study of provision of CIPs training in nursing, medical, and physical therapy degrees offered by 209 public higher education institutions, Salles *et al.*²¹ reported that only 43 of the institutions (32.3%) provided courses on CIPs.

The type of degree that most offered courses in this area was nursing (26.4% of all courses), followed by medicine (17.5% of all courses), and physical therapy (14.6% of all courses).

Residency programs involving CIPs are available mainly for doctors. Approved in 2002 by Federal Medical Council Resolution No. 1634/2002²⁸, two-year (R1 and R2) residency programs are offered in acupuncture (by nine institutions) and homeopathy (by one institution)²¹. For other health professionals, residency programs consist

Chart 1. Themes, strengths and weaknesses related to the implementation of the PNPIC.

Theme	Summary of knowledge	Strengths and weaknesses	Articles
Professional training in CIPs in the SUS	SUS staff are underprepared when it comes to CIPs	Weakness	Thiago e Tesser ¹⁰ Oliveira et al. ¹¹ Cruz e Sampaio ¹² Gonçalves et al. ¹³ Fontenele et al. ¹⁴ Castro et al. ¹⁵ Chehuen Neto et al. ¹⁶
	Provision of CIP training courses tailored to the needs of the SUS is incipient in Brazil	Weakness	Teixeira e Lin ²⁰ Salles et al. ²¹
	Personal use of CIPs by SUS professionals	Strength	Thiago e Tesser ¹⁰ Oliveira et al. ¹¹ Cruz e Sampaio ¹² Gonçalves et al. ¹³ Chehuen Neto et al. ¹⁶ Ischkanian e Pelicioni ¹⁹
Structuring CIP provision, access, and health promotion	Restricted access to CIPs in secondary care services	Weakness	Santanna et al. ²³ Lima et al. ²⁴ Nagai e Queiroz ²⁵
	CIPs in PHC enhances health promotion	Strength	Nagai e Queiroz ²⁵ Silva e Tesser ²⁶ Cintra e Figueiredo ²⁷
Knowledge, access and acceptance of service users in relation to CIPs	Poor knowledge and access to officially recognized CIPs among service users	Weakness	Fontanella et al. ²⁸ Rui et al. ²⁹ Marques et al. ³⁰
	Service users potentially interested in officially recognized CIPs	Strength	Fontanella et al. ²⁸ Rui et al. ²⁹
	Use of informal traditional medicine	Strength	Oliveira et al. ¹¹ Fontanella et al. ²⁸ Oliveira e Salvi ³¹
	Affinity between CIPs and aspects of traditional and religious health practices in Brazil.	Strength	Monteiro e Iriart ³² Justo e Gomes ³³
Knowledge of SUS professional staff and managers in relation to the PNPIC	Poor knowledge of PNPIC among professionals and managers	Weakness	Thiago e Tesser ¹⁰ Chehuen Neto et al. ¹⁶ Ischkanian e Pelicioni ¹⁹ Santos et al. ³⁴ Santos e Tesser ³⁵
Scope and monitoring and evaluation of the PNPIC	Lack of definition of the scope of the PNPIC and registration shortcomings in the SIA-SUS and CNES.	Weakness	Lima et al. ²⁴ Sousa et al. ³⁶ Santos et al. ³⁷

of multiprofessional residencies in family health that rarely offer modules on CIPs²¹.

It is possible that the lack of training courses and programs in CIPs that encompass the principles of public health is due to the low demand for this type of professional in the SUS, especial-

ly given the fact that the implementation of the PNPIC is relatively recent and the lack of specific funding for the policy.

However, a look at the way in which the comprehensive care movement was incorporated in Brazil is also helpful for understanding this gap

in public higher education institutions. Revisiting the history of this movement in Brazil, Matos³⁹ recounts that, unlike in the U.S., comprehensive care was not institutionalized, but rather relegated to the departments of preventive medicine of medical schools. Within this context, the underlying interpretation of comprehensive care was reconfigured and the problem of fragmentation and reductionism in healthcare gained a broader perspective linked to service flow and organization.

For a long time in Brazil, the discussion on comprehensiveness has ceased to give precedence to good medical practice, concentrating on the structuring of services and practices, specific policies and programs, and access to the various levels of care.

Despite the gap in CIP training, Azevedo and Pelicioni²² highlight the existence of promising public education initiatives. With regard to postgraduate training, the authors emphasize research laboratories and working groups in CIPs attached to universities, such as the Medical Rationalities Group at Fluminense Federal University, Laboratory for Research and Practices for Comprehensive Healthcare at the State University of Rio de Janeiro, Laboratory for Complementary, Alternative, and Integrative Healthcare Practices at Campinas State University, and the Complementary Healthcare Practices Group at the University of São Paulo School of Nursing.

With respect to undergraduate degrees, the authors draw attention to recently created courses in public health at the University of São Paulo and Federal University of Rio de Janeiro, where it is expected that CIPs in the SUS will be addressed in order to close the gap in this area and encourage professionals to enter this field.

With regard to continuing education, the National Office for the Coordination of Complementary and Integrative Practices' management report⁵ points to the need to make use of the strategies developed by the Ministry of Health under its National Health Education Policy, including: the SUS Open University System, National Telehealth Program, Continuing Education at Work Program, and specialist training courses and professional master's degrees. With respect to medicinal plants and phytomedicines, local initiatives have been developed in some states and specialist training courses provided by the Ministry of Health include modules on this topic.

Although our findings do not encompass these courses, we believe that such strategies are vital to tackle the professional training and de-

velopment challenges highlighted in the management report and ensure an adequate number of qualified SUS staff in this area, given that they provide training opportunities for health professionals who already work in the SUS.

Structuring the provision of CIPs, access, and health promotion

This category brings together studies that discuss the structuring of CIPs within health services and suggest that the level of care in which CIPs are provided influences access to and the potential of these therapies to promote comprehensiveness via health promotion.

A first set of articles²³⁻²⁵ brings accounts from professionals, service users, and secondary care managers suggesting that access to CIPs is restricted and that there is a high level of suppressed demand, due primarily to the fact that consultations are provided exclusively by doctors.

A solution to this problem appears to be found in the PNPIC, whose strategy is to focus actions on PHC services, given both the capillarity of primary care and the fact that non-medical professionals are able to deliver CIPs via FHSCs⁵.

A recent study that examined the incorporation of CIPs into PHC services in big Brazilian cities showed that the Family Health Strategy (FHS) coupled with matrix teams is the best route to implementing this policy in the SUS. According to the authors, these teams provide specialist rearguard services in PHC, shortening waiting lists and, depending on local management, promoting effective matrix working in the FHS⁴⁰.

It is important to note that CIPs are regulated by the professional bodies that oversee the occupations that carry out a particular practice. Acupuncture, for example, can be practiced by psychologists, physiotherapists, pharmacists, biomedics, biologists, and nurses, facilitating the integration of these actions into PHC services via FHSCs.

Also within this category²⁵⁻²⁷, three studies provide accounts from CIP users in PHC services, showing the appropriation of self-care techniques and tools and lifestyle change, or in other words, health promotion.

Based on current concepts, health promotion is understood from a collective perspective, where actions should be developed within the political, social, institutional, and community sphere with a view to formulating and implementing health policies, creating an enabling environment for

healthcare provision, reinforcing community action, developing personal skills, and reorienting the health system⁴¹.

Although health promotion using CIPs usually takes place in the personal sphere, Tesser⁴² argues that these actions foster socialization and solidarity and are capable of catalyzing collective empowerment, especially when these practices are offered to groups.

According to Barros⁴³, who assigns the FHS and CIPs the status of social movement, the potential of CIPs is particularly relevant for the PNPIC, given that strengthening this policy depends on the coordination and collaboration of the people involved in its implementation – service users, health professionals, and managers, among others.

According to Tesser and Souza⁴⁴, as strategies, PHC and CIPs have *elective affinities* or common aspects that potentiate each other in a context of interaction. For this reason, the authors defend that PHC is the most fertile field for providing these practices because it enables health promotion, which is at the core of CIPs.

Therefore, since the PNPIC is underpinned by the principle of comprehensiveness, the policy's focus on PHC would appear to be emphatic, because it broadens the possibilities to actively include service users as subjects of their treatment and, at the same time, of policy implementation.

Knowledge, access and acceptance of service users in relation to CIPs

This theme draws together exploratory studies that discuss the knowledge, access, and acceptance of SUS service users in relation to CIPs.

In consonance with the PNPIC management reports^{4,5}, which showed that dissemination was a key implementation challenge, three of the studies²⁸⁻³⁰ show that SUS service users have poor knowledge of and access to the CIPs included by the PNPIC. It is worth noting that two of these studies^{28,29} showed that service users were interested in knowing more about the CIPs included by the PNPIC.

Three studies^{11,28,31} also showed that service users had access to informal traditional health practices, particularly the use of medicinal plants. These practices, which are part of Brazilian traditional medicine, have not been incorporated into the PNPIC to any significant degree⁴⁰.

Traditional knowledge of medicinal plants and other tradition-based CAM resources are

understood to play a key role in the implementation of the PNPIC since, besides being an important part of a country's cultural heritage, these practices value the autonomy of users during the treatment process.

Although most of the CIPs do not come from Brazil, the fact that there is a convergence between these practices and many of the essential ethical and philosophical aspects of traditional and religious health practices found throughout the country is a determining factor in their acceptance by the Brazilian population.

Monteiro and Iriart³² argue, for example, that the closeness between homeopathy and the holistic perspective, use of natural medicines, and open and attentive listening, facilitate the acceptance and incorporation of these CIPs by service users, particularly by the working class. In this respect, a study by Justo and Gomes³³ describes the important role played by the Spiritism movement in the consolidation of homeopathy in primary healthcare services in Santos.

Although lack of knowledge and poor access are fundamental weaknesses of the PNPIC, it is important to stress that the affinity between CIPs and many of the health practices rooted in traditional and religious culture in Brazil may also be recognized as a strength of the policy implementation process, since it helps promote the legitimization and acceptance of these practices.

Given the various obstacles to the legitimization of CIPs created by modern institutions, it is necessary to develop alternative strategies to promote social and institutional recognition of these practices. Both service users and professionals should play a key role in this process, making use of the spaces for political participation created within the SUS⁴⁵.

It is worth remembering that the identification of these therapies by international bodies and the Brazilian government resides precisely in their therapeutic pluralism and the otherness of care – that is, in the multiplicity of complementary and traditional practices whose clinical and sociocultural efficacy has been established in history and tradition, well before the existence of biomedicine⁴⁶.

Notwithstanding its limitations, some authors⁴⁷ defend the SUS's therapy pluralization strategy, which involves the valorization and provision of complementary and alternative medicine, because it has the potential to tackle the over-medicalization of the system, despite of the political and epistemological hegemony of biomedicine.

Knowledge of SUS professional staff and managers in relation to the PNPIC

The studies^{10,16,19,34,35} show that SUS professional staff and managers display a poor knowledge of the PNPIC. This is a major weakness, given that, in the absence of adequate resources, policy implementation depends largely on the effective participation of these and other actors within the SUS.

The co-participation of managers, service users, and health professionals is as important to the implementation of the PNPIC as the results of care, because it allows health services to tailor planning to the social, institutional, and political reality of the region and thus promote sustainability⁴⁸.

A study by Santos and Tesser³⁵ examining the implementation of the PNPIC in Recife clearly illustrates this problem. The findings demonstrate that the lack of participation of service users and non-inclusion of health professionals in health policy formulation hindered the consolidation of the policy in the local health service, which had only one service fully up and running five years after the law came into force.

Scope, monitoring and evaluation of the PNPIC

Currently, monitoring of the PNPIC is performed using data from the SUS Outpatient Information System (SIA-SUS, acronym in Portuguese), National Health Establishment Registry System (CNES, acronym in Portuguese) and, more recently, the Primary Health Care Information System/e-SUS, which brings together specific information on CIPs in PHC services. Results from the PMAQ-AB, National Health Survey, and National CIP Registry are also used⁴⁸.

The findings of studies in this category^{26,36,37} point to a lack of definition regarding the scope of the PNPIC, leading to shortcomings in the registration of data pertaining to CIPs in the CNES.

These findings confirm one of the conclusions of the PNPIC management report: monitoring and evaluation is one of the main challenges faced by the policy^{5,6}.

Lima *et al.*²⁴ highlighted registration shortcomings due to the existence of various therapies that may be understood as CIPs but do not have codes on the forms of the CNES and SIA-SUS.

Sousa *et al.*³⁶ highlight the existence of two Ministerial Orders (971/2006⁴⁹ and 853/2006⁵⁰) that leave doubts about the terms *body practi-*

es and other techniques, meaning that CIPs are registered in different ways. The findings show that practices not included in the SIA and CNES forms were registered separately and the improper registration of many practices not included in the PNPIC and/or traditionally associated with biomedical risk factors and understood by managers to be CIPs, such as: handicrafts, walking, and diabetes prevention groups.

Despite recognizing that the policy has brought visibility to CIPs within the SUS information system, the authors suggest that there is a lack of definition of CIPs within the policy, meaning that many practices are not specified in the system and are therefore registered separately by health professionals.

Another problem found by this study refers to the registration of the occupations that carry out CIPs in the SUS. In this respect, the registration nomenclature of the Brazilian Classification of Occupations excludes important information, for example the level of education of the professional and the activity carried out in the service where he/she is registered.

Santos *et al.*³⁷ highlight that this problem made it impossible to distinguish between acupuncturists who were doctors and those who were non-doctors.

The lack of definition of the scope of the PNPIC leads to the inadequate registration of CIPs in the SUS, thus hindering monitoring and evaluation and policy consolidation.

Final considerations

The emergent themes in the present review reiterate some of the challenges highlighted by the PNPIC management reports^{4,5}, providing deeper insight and input on these problems.

The need ensure training and development for an adequate number of SUS staff was reaffirmed. In this respect, personal use of CIPs, the potential interest of professionals in seeking relevant skills and knowledge, and the considerable number of research and education initiatives in public universities could help catalyze this process.

The findings also demonstrate the importance of structuring the provision of officially recognized CIPs on the SUS, with a focus on PHC. It is at this level of care, which accounts for the majority of CIP initiatives, that these therapies reach their full potential, enhancing health promotion and increasing the comprehensiveness of care.

With regard to policy monitoring and evaluation, the findings reveal a need to review the scope of the PNPIC, requiring a clear definition of CIPs and the criteria that enable their incorporation into the SUS. Secondly, the studies point to technical problems in the registration of information, suggesting the need to improve the CNES and SIA-SUS and provide training in how to use the system in order to improve data reliability.

Poor knowledge of the PNPIC and CIPs among professionals/managers and service users, respectively, reaffirms the need to raise public and health professional awareness of these practices. It is important to note that the use of informal traditional medicine and the affinity between many officially recognized CIPs and various traditional practices in Brazil are vital aspects that should be taken into consideration in the planning of communication actions.

However, knowledge of the PNPIC among professionals, service users, and managers is only a first step towards the sustainable implementation of the PNPIC, which should involve participatory planning and ensure that care actions

are tailored to the local reality and needs of the health region.

Moreover, in the absence of adequate resources for the effective implementation of the PNPIC, it is vital that this policy is defended in local, state, and national health councils and across the different levels of government. While the creation of a legal framework has deepened the institutionalization of CIPs in the SUS, local and state legislation is required to ensure the correct allocation of resources and regulation of services^{6,27} in order to address policy implementation challenges.

Other challenges highlighted by the PNPIC management reports^{5,6}, such as the adequate provision of supplies and materials and investment in research and development of products, did not appear in the selected articles, which may be regarded as one of the limitations of this study.

Considering the threats to the SUS and its underlying principles posed by the current political environment, it is hoped that this work will contribute to the debate about the PNPIC and, above all, reaffirm the need for political articulation on the part of the actors involved in the process to ensure its progress.

Collaborations

PHL Habimorad participated in study conception, research, and the drafting of the final version of this manuscript. RS Spagnuolo, KP Patrício, and M Demarzo participated in the definition of methodology and drafting of this manuscript. FM Catarucci, VHT Bruno, and I Beteto participated in the drafting of this manuscript. V Campolina participated in research and the drafting of this manuscript.

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