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The More Doctors for Brazil Project – challenges and contributions to Primary Care in the vision of the cooperated physicians

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The More Doctors in Brazil Project (MDBP) was created in 2013 in order to supply physicians for areas where it is difficult to retain professionals and to provide training in family and community medicine for Brazilian and foreign physicians. This paper examines aspects related to motivations and work processes and conditions in primary health care; the health situation in cities, operation of the of the Brazilian National Health System (SUS), and the relationship with managers. This study is based on interviews with 44 Cuban physicians who are working in 32 cities in all regions of the country. The results showed that the affiliated physicians have an acute sense of observation and are able to make a detailed situational analysis of the areas where they work. The findings also indicated that primary care is still precarious in these cities. However, they also demonstrated that with adequate training it is possible to provide quality primary care, even in the midst of major challenges.

Keywords: Primary Health Care. Public Health. Rural areas. Medical education.

Introduction

On October 16, 2013, the Federal Senate ratified the decision of the lower house and approved Provisional Measure 621/2013, which created the More Doctors Program; it was then submitted for presidential approval and became Law No. 12871 of October 22, 2013. The text of the law indicates that achieving the objectives of the program depends on reorganizing the supply of courses in medicine and places for medical residencies, based on parameters for reaching regions with the lowest ratio of places and physicians per inhabitant. Additional objectives are establishing new parameters for medical training in the country and promoting the development of primary care physicians in priority regions of the (SUS). Part of the larger program is the More Doctors in Brazil Project (MDBP) (Articles 13 to 21 of Law No. 12781/2013), in which participating physicians, hired through official recruitment notices, work in the country with temporary registration issued by the Ministry of Health. However, those who wish to continue practicing medicine in Brazil after their three years in the program will be required to have their foreign diplomas recognized[1].

Between August 2013 and July 2014, the MDBP brought 14,462 physicians to all regions of Brazil. Considering the scope of the program, it is important to assess its effectiveness as an initiative that ensures the right of universal access to health, through improved access of the population to healthcare networks. The MDBP provides an opportunity to study the baseline and its possible repercussions in the organization of flows of supply and demand, the structuring of the provision of health services, and consolidation of health service networks in the country.

In 2014, initiatives were launched to conduct empirical studies that could evaluate the impacts of the MDBP and provide input for the decision-making process of federal, state and municipal managers, aimed at improving public interventions in health. This paper stems from one of these initiatives, with a specific focus on the views of affiliated physicians on primary care in Brazil and the SUS and how they feel the MDBP influences its implementation and strengthening.

Methodology

This was a qualitative study, carried out in 32 randomly selected cities according to the following inclusion criteria: a) 20% or more of the population lives in extreme poverty; b) be enrolled in the first or second cycle of the MDBP; c) have fewer than five physicians serving the population; d) have less than 0.5 physicians per 1,000 inhabitants in June 2013.

The weighted probability sample was divided in proportion to the number of cities with the aforementioned characteristics. After applying the inclusion criteria, there were 32 cities in all regions of Brazil: 14 in the North, 12 in the Northeast, three in the Southeast, two in the Center-West and one in the South[g]. Forty-four semi-structured interviews with physicians from the cities included in the sample (16 men and 28 women) were analyzed. In this paper, it was decided to use the term "affiliated physicians," since it is the one most used by the Ministry of Health due to the cooperation agreement between Brazil and Cuba, which was intermediated by the Pan American Health Organization/World Health Organization (PAHO/WHO).

One interview was conducted in cities that had one physician from the MDBP and two in cities that had two or more physicians from the program. It was also decided to only consider the registrations of physicians of Cuban nationality, since these professionals have specific previous training in primary care/family medicine and represent the absolute majority of the physicians in the program.

Based on the content of the interviews with the physicians, the information was categorized and the results were quantified, using the quantitative and descriptive analysis technique (frequency). The software Atlas.ti version 7 and content analysis techniques were used[2,3].

The following thematic categories emerged from the interviews: motivations for participating in the MDBP; work processes and conditions in primary care; the health situation in the cities; operation of the SUS; and the relationship between physicians and managers.

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[g] This research is part of a multicenter project entitled: "Analysis of the effectiveness of the More Doctors initiative in achieving the universal right to health and consolidation of the Health Services Network", financed by the CNPq and Department of Science and Technology of the Ministry of Health, through Public Invitation MCTI/CNPq/CT-Saúde/MS/SCTIE/Decit No. 41/2013.

The field work was conducted between November 2014 and June 2015. This was the first stage of the evaluation of the project, which will occur in three stages. Besides physicians, the project will also involve managers, other health professionals and users from the selected cities.

The study was approved by the Research Ethics Committee of the Faculty of Health Sciences of the University of Brasilia and all the physicians interviewed signed free and informed consent form, which outlined the objectives of the study and the conditions of participation.

Results

A. Motivations

Among the motivations cited by the Cuban professionals for participating in the MDBP were the relationship between medical training in their country and the dimension of international service, as well as solidarity, where "collaboration to help and serve" is part of the Cuban professional training process.

> In our training, there is a fundamental premise of internationalism and providing service wherever our services are needed [...] I had to fulfill a mission here in Brazil, a project in a needier region, and I took a stand to participate here and help improve health in Brazil [...] (Dr. 28 – PA).

> The reason was that solidarity is cultivated right from the cradle, so when this proposal was launched in our country, we were all very inspired. Brazil was a country we all liked (Dr. 23 – AP).

Others referred to the "dream" of getting to know Brazil and the SUS, travel in other cultures, and learn about other experiences, ways of life and different diseases. The economic aspect was also sometimes mentioned, with participation being considered a "good financial opportunity," as well as meeting a requirement of the

Cuban government. It stood out that many professionals that were in Brazil had already had similar experiences in other countries, particularly countries in Latin America, such as Venezuela, Bolivia, Honduras and Mexico, in addition to countries from other continents, such as China and Nigeria. Many had even stayed in these countries for a few years, as seen in the following remarks.

> In Venezuela, the "Barrio Adentro" mission (Into the Neighborhood) was also very nice. We arrived in Venezuela the first time in November 2003. I also worked in a rural area in the center of Venezuela [...] as a general physician and in community medicine. The experience was very good, because in the beginning I didn't have an office to work in and we started house-to-house work (Dr. 20 - PA).

> I started my career in Cuba and had a chance to work in Venezuela. This was also a great professional experience and I gained a lot of knowledge, in addition to sharing with other cultures and customs, which always results in personal, professional and human enrichment. 23 - AP).

For other professionals, experience in Cuba was also an important element that motivated them to practice medicine in other countries, having exercised the profession in rural areas, within the scope of primary health care and integrative medicine, and in lower-income medical centers:

> Since starting my career, I've worked in the countryside, like here. In the rural area there, they gave me a house and everything I needed for the job (Dr. 1 - PR).

> I stayed in Cuba for two years working as a municipal advisor for the Mother and Child Care Program. Two years later I went to Bolivia [...]. I went back to Cuba and continued working there another two years, seeing patients, in a low-income medical center, being on duty [...] (Dr. 21 - PA).

B. Work processes and conditions in primary care

One of the first observations in the interviews with these professionals referred to the organization of the workday. The physicians said they generally worked eight hours a day, except for Friday. On that day they had to attend the family health specialization course that is part of the agreed duties in the MDBP, in order to help train visiting physicians on how the primary health care model is structured in Brazil and to develop continuing education strategies. According to some of the interviewees, the schedule had to be strictly followed, since the physicians needed to be available to serve the public. However, this daily schedule could go into overtime because of the need to care for patients who arrived spontaneously, emergency situations, or house calls in distant areas. In addition, it can be noted that the daily work was organized around the characteristics of the places where they were stationed and according to local needs. In a typical situation, one physician said:

I see patients from 8 am to 12:30 pm, more or less. In the afternoon, I see patients from 2 pm to 5 pm or I do house calls all afternoon (Dr. 2 - MG).

The professionals mentioned the inconvenience of getting to the health unit and the length of time it took, since in many cases the communities where they worked were far from the center of the cities where they resided. Sometimes, due to lack of gasoline or transportation, they were unable to get to the primary healthcare units and needed to walk long distances or get their own transportation.

Regarding the organization of the work, the physicians said they had scheduled appointments as well as people who arrived spontaneously at the units, in addition to consultations related to specific programs (diabetes, hypertension, children and puerpera, among others). They did house calls, where they saw and counseled seniors, children, pregnant women, people with mental illnesses, those who are bedridden, etc. They also engaged in educational activities (mainly in the form of talks) at the primary healthcare unit, in schools or on radio stations in the cities. During these activities, they addressed various subjects that were related to the health programs or relevant

public health issues. They also attended regular meetings that took place monthly, weekly or every 15 days, for the purpose of planning unit activities.

Although they knew they were only authorized by the Ministry of Health to exercise their profession in primary care activities covered by the program and in locations determined by the ministry, and could not provide emergency care, in some cases they did so, since in their opinion, "people's lives are more important". The most frequently reported activities can be seen in the following remarks:

> The daily schedule is divided into seeing patients in the unit (scheduled appointments, emergency situations, care for pregnant women and children); one shift is used for house calls, one day to go to rural areas in different places; one shift to meet with the FHP team and for educational activities in the schools, when there are theme-based campaigns (Dr. 10 - AL).

According to the interviews, the number of patients seen per day varied from 10 to 15 people. For some, the average number seen in a day ranged from 25 to 35 patients, which was considered a high level. There was also a considerable difference depending on the day of the week. Another factor that influenced the number of consultations was the time spent with each patient. Some said it varied from 10 to 15 minutes, or even up to 20, since there were many patients in relation to the low number of working hours. They explained that the time spent depended on various factors, such as: the disease investigated; the patient (whether a returning patient or one coming for the first time); age; community of origin; type of physical exams that needed to be done; the need to listen to the patient and do a detailed anamnesis; instructions about the medical prescription; and whether it was a normal or emergency consultation. Pregnant women and patients with mental illness required more time. A consultation could extend up to 40 minutes, if necessary, depending on the patient's clinical situation, including ordering of tests, and especially if it was the person's first visit.

> Depending on the pathology, there are patients and patients; I spend the time needed and don't watch the clock. We try to see what the patient has and reach a conclusion (Dr. 4 - AP).

Most of the time, house calls were carried out with community health agents, but they could also occur with nurses and/or other members of the team. According to them, there were currently more visits than before. In some cases, the request could be made by the physician when they noticed in consultations in the unit the need to follow up on a particular situation more closely. The scheduling of house calls was not necessarily fixed and might occur only when a member of the team considered it necessary, or once or twice a week, in the morning or afternoon, generally after 3 pm. According to the affiliated physicians, at the time of a house call they checked out the economic situation, the family's health status, the route from one house to the next, the overall environment, yards, if there was garbage, standing water or weeds, if sodium hypochlorite was used, how it was used, and the procedures for preparing the children's food, i.e., “the general living conditions of the person and anything that could be harmful to the health of the population,” in addition to addressing the issue that gave rise to the house call. The number of homes visited per week fluctuated, and could be between two and ten. In one day of visits, ten to 15 patients might be seen.

In relation to house calls, one physician said:

> We look at the house, the relationship of the user with the family, of the family with the user and of the user in relation to him or herself, as well as doing health education, promotion and rehabilitation. The profile of users who receive house calls is older people unable to walk, those who are bedridden, women who are puerperal or recovering from a C-section. There may be a variety of reasons for a visit, provided there is a need. We do up to four visits at a time (Dr. 9 - BA).

The main difficulties reported in doing house calls were related to lack of transportation on the part of city authorities. Mobility was mainly via car or motor boat

(especially in the North region) when it was a riverside community, or even by motorcycle. The vehicles sometimes belonged to the physicians or professionals working on the team. Car accidents had even occurred over the course of visits. Rainy season was always an impediment, since transportation was often unable to reach difficult-to-access locations.

Another problem that was pointed out was safety. Some physicians reported that they no longer did house calls because they had been assaulted, and had requested more security without obtaining any response from the public authorities.

C. The situation of primary care and health in the cities

Regarding the health situation in the cities, most of the physicians indicated that certain diseases and disorders were detected more often, such as: hypertension, obesity, hypercholesterolemia, diabetes, mental illness, heart diseases, respiratory diseases, bronchial asthma, pain in the dorsal and lumbar regions, strokes, motorcycle accidents, drug use and alcoholism. Other physicians mentioned the frequent occurrence of infectious diseases in their cities, such as diarrhea, sexually transmitted diseases (HIV, condyloma, and syphilis), leishmaniasis, leprosy, tuberculosis, helminthiasis, dengue, influenza, malaria and hepatitis. Some occurred only in the rainy season, and others were closely associated with consumption of poor quality water and the existence of untreated sewage.

In the view of many interviewees, there were a number of difficult or critical situations and significant lack of medical care in the cities. Others had imagined that the situation would be worse, since they were aware of the health situation in other countries and also other cities in Brazil where they knew a physician. Some expected a higher prevalence of disease, due to the poverty of the cities served by the program.

According to them, the cities need to promote forms of local development and the implementation of policies to overcome problems with inappropriate environmental conditions, trash management, drinking water and the presence of animals that transmit diseases, while recognizing that the population is large and

human resources are scant. However, there were also some physicians who considered that the situation of their city was good, despite the difficulties.

The physicians reported various urgent situations, such as numerous people taking prescription and/or over-the-counter drugs, disorganization in municipal primary care, incomplete health teams, interrupted flow of regular patient follow-up, and lack of initiatives for health prevention, promotion and rehabilitation.

From the point of view of these professionals, some cultural practices and lack of education in health contribute to the persistence of certain diseases that could be resolved through educational processes and preventive measures, since they are avoidable diseases. However, this would require changes and organizing the components of the primary healthcare network in order to improve the indicators. They emphasized, in a positive way, that with work, dedication and love, it would be possible to make these changes and help create better living and health conditions.

However, it needs to be understood that the social vulnerability of the population represents a major challenge for initiatives involving education in health, due to low educational levels and the existence of lifestyles that are difficult to change. Given their living circumstances, people often have unhealthy eating habits (salty and fatty foods, with little fruit, vegetables and legumes).

In the opinion of some professionals, however, the social vulnerability of the communities does not affect their work, since poverty is not an insurmountable obstacle for health. In many cases, the population lives close to the health unit and the physicians carry out educational activities. Nevertheless, according to the interviewees, more work is needed, as well as increasing the number of educational talks and providing the community health agents with supplementary courses for the residents of the community, and this is something that motivates them to work harder.

> Here [...] we need to understand that people are poor, the educational level is low, hygiene habits also have an influence on epidemiological conditions [...] Therefore, many factors have an influence. Nonetheless, I feel we have changed the city's health profile a little (Dr. 28 - PA).

D. Assessment of the operation of the SUS and the relationship with managers.

Regarding health services, the physicians said that organizational improvements need to be made, due to the existence of various problems such as constant shortages of drugs and lack of fuel for transporting physicians, which prevents making house calls; frequent changes of managers; insufficient resources for providing daily care; and lack of on-duty medical professionals in the hospitals (resulting in them having to care for these patients).

This testimony from one physician illustrates the deficiencies: "To carry out the work in the unit, the most difficult aspect is lack of supplies, having drugs for patients, so that they can go away with the indicated medication and do their treatments in order to be healed. If they have a fever, we need to be able to give them an injection, and have syringes, needles, drugs (Dr. 27 - PA)".

The laboratories do not function properly and there are difficulties scheduling appointments with medical specialists. On top of these problems are limitations in the infrastructure of the Family Health Strategy units (many are being renovated or under construction). The physicians reported various obstacles to providing adequate care, such as lack of ventilation in the medical offices (physicians needed to bring their own fans), no bathroom in many cases, insufficient lighting and no wound dressing room, nursing room or even a vaccination room. Most of the interviewees also reported that basic equipment was lacking, such as otoscopes, bandages, stethoscopes, measuring tapes, scales, sphygmomanometers, leprosy kits, tweezers, gynecological speculums, suture material, glucose meters, negatoscopes, electrocardiographs and stretchers. Finally, they mentioned problems with referrals and counter-referrals. For example, when the patient is referred to a specialist, there is a long delay between the request and the assessment by that professional. For this reason, many patients, when they can, end up seeking a private physician due to this delay.

> Right now, the hospital is under renovation. This creates a problem in referring patients who urgently need it. This gets my attention because it is the primary care here, going to the hospital. There's a problem doing X-rays, there's no electrocardiogram, no mammograph (Dr. 41 - AM).

According to the interviewees, there were also frequent difficulties getting the tests that were requested by the physicians done, since some of them were only available in state capitals, which were distant, often making it impossible to do them, resulting in the patient not receiving a full analysis. Among the transportation problems mentioned was lack of or insufficient ambulances to take patients for treatment. However, a small number of affiliated physicians felt that although the situation was not perfect, it was nonetheless good, since they felt that good care was given, patients were referred when necessary, the services were better organized in these cases, and their primary healthcare units were well-equipped. There were complete teams with dentists, physicians, nurses and community health agents. They also referred to good integration with hospitals, mobile emergency services, family health support centers and ambulances, etc.

The interviews revealed difficulties in doing follow-up on patients for situations that could be resolved at this level of care, but certain adequate basic equipment was lacking: "We have a major problem with pregnant women. We don't have a stethoscope [...] for detecting fetal heart rate. We have problems with this. Right now I do it with my own stethoscope, which is difficult, but I try to listen to the fetal heart beat. (Dr. 37 - PA)".

However, in the relationship with managers and other professionals, the physicians reported good interactions, since they tried to solve whatever problems the physicians had. The physicians said they share everything with them and that, in general, no problems had occurred with other medical specialists or physicians on duty. There was a good relationship with all the professionals, not only for work, but there was also friendship. The physicians felt welcomed by these people, who always

asked if everything was okay. They were like a family. Some even felt as though they were in Cuba.

According to one of the interviewees:

> The relationship with the managers and other professionals is good, with all the professionals with whom we interact. The staff from the Family Health Support Center is very receptive and whenever I need them, they always come through. Whatever is in their power to do, they do it. I have no complaints at all. The same with the staff from the CTA. In the administration office as well [...] They've been very welcoming (Dr. 25 - PA).

Discussion

The results of this study demonstrated that affiliated physicians were motivated to work in remote regions where it is difficult to supply physicians, the main objective of the MDBP. Solidarity was a recurrent theme in the remarks of these physicians, as a value that inspired willingness to help people living in faraway regions with little access to health services. It is social solidarity in the collective realm, which extends beyond borders and is based on the bond of reciprocal recognition between people, i.e., on people's needs as social beings[4].

Ethical-humanistic education, which presupposes inclusion of the subjective dimensions of illness and gives greater visibility to cultural and social issues, in an amplified understanding of the health-disease process[5], helps reinforce the sense of social responsibility of physicians[6].

In addition, many of the physicians had already had previous experience working in primary health care and in other countries. The need to provide services in other countries is included in the Cuban medical education process[6]. Therefore, physicians must be willing to fulfill "missions," i.e., go to other countries that need help, more specifically, medical manpower. They also recognize the benefits resulting from opportunities for physicians to work in different countries, apart from increasing their technical skills and knowledge of new diseases and different health systems[7, 8].

In primary care, the physicians were primarily inserted into FHS units, which have a particular form of organization, committed to changing the primary healthcare model. This is based on the following assumptions: a belief that health is related to quality of life; the idea of health teams; intervention of these teams in families and communities; and inter-sectoral action.

It is evident that medical consultations and house calls and the presence of physicians in the area are central in the organization of the work process of the FHS. The physicians demonstrated strong commitment to fulfilling their weekly working hours, understanding, in particular, that the local population needed their care. It is clear that the demand for medical care, especially consultations, is quite intense and dictates a pace that often makes it difficult to provide more humanized and qualified care to people. Nevertheless, the interviewees were flexible in relation to spontaneous demand, as well as urgent and emergency situations (even if outside their specific duties), especially due to the lack of services in their regions to attend to these needs.

Besides consultations, the physicians reported engaging in educational activities, especially talks in the health units for hypertensive and diabetic groups, as well as in schools and communities. They also did house calls, primarily for people with mobility problems, but also on their own initiative. In these visits, the profile of the physicians appeared to include skills related to surveillance, which included checking out the environment and the socio-sanitary and living conditions of the people in their assigned areas. This "scouting" work, i.e., work that goes beyond the walls of family health units – primarily house visits – was given a high value by the affiliated physicians.

As far as the health situation in remote areas, a complex epidemiological profile was noted, where chronic diseases, infectious diseases and diseases resulting from want and poverty coexist simultaneously. In this regard, some affiliated physicians were rather perplexed, since they did not expect to find this situation in a rich country like Brazil.

Despite their enthusiasm about addressing the care of very socially vulnerable populations, the way physicians sometimes perceived the needs of the population and

organized care practices suggests a strong influence of the biomedical paradigm, which can blame users for their health difficulties. The data from this study demonstrates that regardless of investments in Cuban medical education to work in primary care, the hegemonic paradigm also influences their practices. This paradigm limits the analysis of the social, historical and cultural determinants of health and should be continually questioned in medical education and practice.

Moreover, this model can reinforce the logic of medicalization that prevails in Western health care, including the Brazilian system, and is harmful because it reduces potential investment in the quality of life of the population. To change this mentality, it is necessary to assign greater value to primary care and humanistic knowledge, in an expanded clinical way of thinking that recognizes that the givers and receivers of care have subjective perspectives that can mutually influence their encounters[9]. In other words, the focus must be on comprehensive care, with creation of effective bonds. This gives rise to new levels of dialogue that are focused, not only on disease, but on the larger situation of patients, their suffering, and their psychological, social and existential conditions[9].

Teamwork was considered satisfactory. It appears to fall somewhere between the functionalist model, where professionals are responsible for their own tasks, with physicians being central figures in the work process, and the collaborative model, in which all workers share in the health care of families and communities[10]. There were signs of work-sharing in team meetings, but the interviews also indicated weaknesses in the planning of actions for communities, notably in terms of inter-sectoral initiatives. Although the professionals reported engaging in health promotion and prevention activities (talks to the public and tips to people during house calls), these still occupied a lesser place in the planning of health units.

The precariousness of the infrastructure of the health system in remote areas, and also in urban areas around the country, represent one of the biggest challenges for implementing quality primary care, according to various statements from the Federal Council of Medicine[11] and the results of the outside evaluation of the federal government's National Program for Access and Quality Improvement in Primary

Care[12,13]. Shortcomings in services, such as inadequate physical environments, lack of transportation, problems with the referral and counter-referral system, and even shortages in basic supplies for providing care, along with deficiencies in local health systems that do not have safe laboratories, medical specialists and other medium- and high-complexity services, are a major bottleneck for adequate care of the population.

Despite good interactions with most local managers, the physicians said they felt the need for better communication with decision-makers to discuss issues related to improvements in the infrastructure of the services and local health systems. As affiliated physicians, they can and should demonstrate engagement in improving the health system of the country where they are providing services.

There was also a notable need to invest more in teamwork, which also takes into consideration the importance of the participation of users and communities. In this aspect, it is also necessary to invest in the education in health for users and communities because of culturally conditioned expectations that physicians will see them quickly, request tests and medicate them, without much discussion[9]. As the results of this study suggest, this education, should not just be viewed as transmission of medical knowledge through the act of instilling, transferring and transmitting values and knowledge. It is important that it be based on a dialogical approach, where users of health services and their communities are recognized as possessing knowledge that could serve as the basis for freeing and redefining the health-disease-care process[9].

Brazil is still experiencing a major shortage of human resources in the area of health in relation to rural areas and among the socially and economically more vulnerable populations[14,15] that are the primary focus of the MDBP. Although controversial, the MDBP significantly expands access to and effectiveness of primary care in the country[16-18], which helps universalize primary care and strengthens the problem-solving capacity of the national health system, and these elements are currently considered essential for a large number of nations[19,20].

Final considerations

Investments to bring trained foreign professionals with a specialization in family and community medicine, especially Cuban physicians, expand access to primary care in remote areas and improve its quality.

Despite the short time spent in the cities (between 6 and 12 months for most), the affiliated physicians were able to provide a detailed situational analysis that illustrated the precariousness of primary care, which has long been reported by medical associations and the population. However, the results also demonstrated that, with adequate training and professional dedication, it is possible to provide quality primary care, even in the face of major challenges.

The interviews were conducted during the initial implementation period of the MDBP (2014 - 2015), when the professionals had little experience in their work locations. Therefore it is necessary to wait for the next stages of the evaluation to study consolidation and changes in the opinions of the professionals and determine which goals of the program have been effectively achieved.

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Collaborators

1 - Hilton P. Silva: Coordination of the research, design of the paper, primary and secondary data analysis, initial writing of the paper, final review of the paper, submission.

2 - Roseane Bittencourt Tavares: Data collection in the field, preparation of the databases, primary data analysis, literature review and writing of the paper.

3 - Yamila Comes: Development of the research methodology, description of the research methodology in the paper, translation of the abstract into Spanish and support for writing the paper.

4 - Lucélia Luis Pereira: Methodological description in the paper, translation of the abstract into English, discussion of the data, review of the paper.

5 - Helena Eri Shimizu: Secondary data analysis, writing of the discussion and review of the paper.

6 - Edgar Merchan-Hamann: Discussion of the results, writing of the discussion and final review of the paper.

7 - Ximena Pamela Bermúdez: Analysis and discussion of the secondary data, literature review and final formatting of the paper.

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