DOI: 10.1590/1413-81232018249.27472017

Literature review on the implications of decriminalization for the care of drug users in Portugal and Brazil

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Abstract *Introduction: Substance use problems remain at the core of public concern in countries sharing a common culture and a distinct history like Brazil and Portugal. Objective: To describe findings of scientific literature about the implications of drug legislation change for the care of drug users in Brazil and Portugal. Methods: This is an integrative review of literature that considers inclusion and exclusion criteria, sample selection, analyses and categorization of 21 articles selected that were published in databases PubMed, SciELO and Biblioteca do Conhecimento on-line (BON) and included ordinances and laws related to the subject. Results: We observed that production on the repercussions of changes of legislation on care is scarce. Alcohol and tobacco are still a matter of concern in both countries. In Portugal, concerns about heroin-related issues have declined in recent years, but opioids use prevalence rates remain well above those of Brazil. Crack-related problems are a Brazilian reality without parallel in Portugal. In both cases, some actions are in place to change the policy in favor of a reduced repressive approach, with differentiation between users and drug dealers, increased punishment of dealers and reduced punishment of drug users.*

Key words *Brazil, Drug, Public policies, Portugal, Legislation*

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Introduction

Drug legislation changes in Portugal more than 10 years ago have been followed by changes in care in that country. At the same time, changes also occur in Brazil. Knowing the effects of law changes in different countries can save efforts, share knowledge and learn from existing experiences. Even considering different contexts between Brazil and Portugal, there is no doubt we share other similarities besides historical and cultural roots. Knowing the implications for the care of people with health needs due to alcohol and/or other drugs that resulted from changes in Portuguese and Brazilian Law was the reason we chose these countries for the study.

Knowing its effects can facilitate both the adequacy of care services and improvement of legislation and, especially, dialogue between institutions and professionals in the fields of Justice and Health in both countries. This study aims to describe an integrative review of the literature on the changes in health and care systems that provide care to people with health needs arising from the use of alcohol and/or other drugs, in drug laws and how law changes affect the care of these people in both countries.

Brazil is a trafficking route because it has a large border with the cocaine and marijuana producing countries that are shipped by sea and air to the largest consumer markets in the world. The availability of drugs generated in this trade and inefficient border policing, as well as social factors such as poverty, social inequality and insufficient investment in social policies (health, culture and education) favor a conducive environment for the growing Brazilian illicit drugs consumer market[1].

Portuguese society was conservative until the late 1960s and early 1970s, barely open to modern Western societies, governed by a military dictatorship and strongly influenced by the Catholic Church. That is why the drug use phenomenon started later and with less impact than in other European countries. In Portugal, first users were mostly military personnel who used cannabis when returning from former Portuguese African colonies, where this use was common, and migrants of Pakistani and Indian origin in Mozambique who used heroin[2]. The fall of the military regime and the sudden opening of the country to the rest of Europe led to a considerable increase in drug use, which, together with a deep lack of information about psychotropic substances and their different effects originated a type of consumption with a high rate of associated problems – especially among heroin users. On the other hand, in 1997, in a study of the European Commission[3], Portuguese indicated drugs as the main social problem of the country.

Epidemiological data

As shown in Table 1, alcohol and tobacco are the drugs most consumed in both countries. In addition, in Brazil in 2005, marijuana (8.8%), solvents (6.1%) and benzodiazepines (5.6%) were the drugs most used in lifetime. Comparisons between surveys conducted in 2001 and 2005 in Brazil showed increased estimates of lifetime use of marijuana, solvents, benzodiazepines, cocaine, stimulants, hallucinogens and crack[4]. Among public and private primary and secondary school students of Brazilian capitals, lifetime use of drugs (including alcohol and tobacco) decreased between 2004 and 2010[5]. In this period, lifetime use of crack was stable at 0.7 % in this population.

In the last decades, concern with the growing crack use joined in the main current public health and social problems in Brazil. Some 370,000 crack users are estimated in the main capitals of the country and the Federal District[6], most of them living in situations of social vulnerability, with health problems and use of other legal and illegal drugs[7].

Methods

This integrative review aims to describe the findings of scientific literature on the implications of drug law changes for care actions in Brazil and Portugal. Papers published in journals indexed in databases SciELO, PubMed and the Online Library of Knowledge (B-on) were collected. For this study, criteria for the inclusion and exclusion of papers on the general theme "Care" and criteria on the general theme "Legislation" were defined. The criteria used to select them by titles were:

CARE. Inclusion: original papers describing the network of care for people with substance problems, including critiques, histories, more local or more comprehensive descriptions of the network. *Exclusion*: papers dealing with alcohol for purposes other than human consumption (e.g. fuel); papers describing studies on specific treatment approaches (e.g. clinical trials, case reports, etc.) or prevention.

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Table 1. Prevalence of drug use (%) in lifetime and in the last 30 days in population surveys in Brazil and Portugal.

	Brazil[4]		Portugal[5]	
	Lifetime use	Use in the last 30 days	Lifetime use	Use in the last 30 days
Alcohol	74.6	38.3	73.6	50.3
Tobacco	44	18.4	46.2	26.3
Cocaine (inhaled)	2.9	0.4	1.2	0.1
Cocaine (crack)	0.7	0.1		
Inhalants	6.1	0.4	*	*
Benzodiazepines	5.6	1.3	*	*
Marijuana	8.8	1.9	9.4	1.7
Heroin	0.1	0.0	0.6	0.0
Hallucinogens	1.1	0.2		
LSD			0.6	0.6
Mushrooms			*	*
Ectasy	*	*	1.3	0.2
Amphetamines	3.2	0.3	0.5	0.0

* No information in the cited study.

Legislation. Inclusion: original papers describing illicit drug laws, including critiques, histories and description. Exclusion: papers addressing drinking and driving laws and laws on advertising, sale or use of alcoholic drinks and tobacco.

Portuguese keywords *droga, álcool, política, Brasil, Portugal, lei, legislação, rede, assistência and reforma psiquiátrica* and their equivalent in English: *drug, alcohol, policy, Brazil, Portugal, law, legislation, network, assistance, treatment and psychiatric reform* were used. They were used in aggregate form: the terms *Brasil* or *Portugal* together with the terms *droga* or *álcool* and in conjunction with each of the other terms. Thus, they were used to construct each line of search and a similar procedure was carried out with the terms in English.

Papers found with these keywords were selected by titles, according to inclusion and exclusion criteria. All selected abstracts were read and selected for full-text reading according to inclusion and exclusion criteria. Each of these steps was performed by two researchers to avoid selection bias. The full-text reading of papers identified topics covered shown in the Results section. Integrative review procedures are described in Figure 1.

Ordinances and laws related to the topics care and legislation on drugs referenced in the papers found were included in the review.

Results

In general, papers found are descriptive, with a critical approach both to the history of the trend of legislation and to the implementation of the care network in the two countries. We found few articles (n = 3) that specifically discussed the implication of law changes for care in Portugal and none about the Brazilian context. A brief description of the themes covered in the papers is shown below.

Brazil - Legislation

Problems arising from drug use in Brazil were first perceived as a social concern in the late nineteenth and early twentieth centuries. Thus, Decree Nº 4.294 of 1921 provided legal grounds for detentions and arrests of users and sellers of illicit drugs[9]. The medical-sanitary model that sees users as sick and incapacitated people in need of treatment, and traders as offenders to be punished prevailed until the beginning of the military dictatorship[10]. Then, in 1964, a "warlike model of criminal policy for drugs" was progressively implanted in the period[10].

From the 1960s onwards, the use of various drugs was widespread in the media of protests against governments and wars and became a subversion symbol. In this context, the list of illicit substances was expanded, users were compared

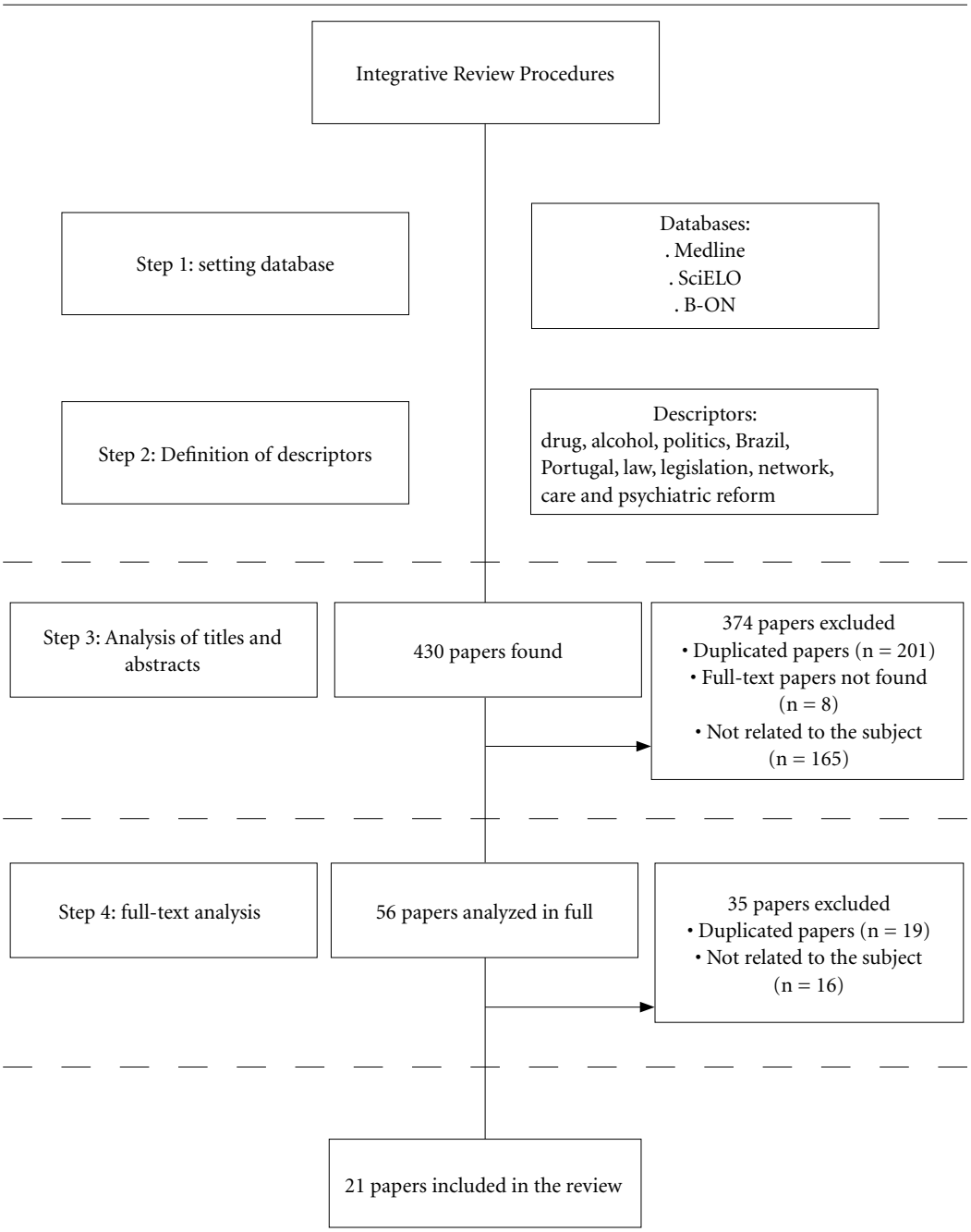

Figure 1. Integrative Review Procedures.

to traffickers, apology, planting and producing was prohibited, penalties were hardened and enforcement and repression started. Following pullback of some repressive policies of the military dictatorship in Brazil in the 1970s, the 1976 toxic substances law recognized the importance of preventive and treatment strategies for drug addiction. From then on, the laws begin to harden against trafficking and slow down for drug use.

Following this trend, the 1990 Heinous Crimes Act equated illicit drug trafficking with the most serious crimes, while the 1998 Alternative Penalties Act was proposed to prevent most

users from suffering prison sentences. In 1997, São Paulo enacted a state law that regulated harm reduction policies (HR). A federal law was enacted with the same objective only in 2005.

Following the guidelines of the Twentieth Special Session of the UN General Assembly (UNGASS), held in 1998 to discuss the world drug problem, Brazil created the National Anti-Drug Council (CONAD) as a collegiate body for guidance in its field of action, and the National Anti-Drug Policies Secretariat (SENAD), which elaborates official anti-drug policies, together with the Federal Police Department[11].

At the same time, after a controversial beginning, HR strategies initially focused on the prevention of communicable diseases[12]. These strategies were progressively assimilated in health policies in the country and have proved useful as an initial approach to users, in different motivational phases[13] and in their consumption environments[14].

In 2002, "The New Toxic Substances Law" was adopted, and the "National Anti-Drug Policy" based on the tripod prevention-treatment-repression was implemented. In 2005, this policy was replaced by the "National Drugs Policy", which prioritized prevention. It created new strategies, such as the taxation of alcoholic beverages and tobacco to generate resources for user treatment, reaffirmed HR policies and did not mention forced treatment as a strategy to be followed, as quoted by the previous version. Thus, the health policy for drug users established in 2003 sought to break with the repressive tradition of the legal apparatus[14].

According to Machado and Miranda[15], some practices originating from the field of control and repression played an important role in favor of the process of establishing a specific health policy. This is the case of the Federal Council of Narcotics (CONFEN) and the National Anti-Drug Policies Secretariat (SENAD), which contributed to the implementation of HR programs and stimulated the work of treatment, research and prevention centers.

Thus, the drug policy in the late twentieth century is characterized by the coexistence of prohibitionist laws, with distinction between users and traffickers and admission of HR strategies.

Law 11.343 enacted in 2006 remains in force to date. It prescribes measures to prevent abuse, care and social reintegration of users and drug addicts. The law treated traffickers and users differently. Regarding the possession of drugs for personal use, retributive justice based on punishment was replaced by restorative justice, whose main purpose was resocialization through alternative penalties, such as a warning about the effects of drugs, provision of services to the community that address prevention/recovery of users and educational measures. As a result, drug possession was decriminalized in Brazil, which ended the sentence of deprivation of freedom[16]. Despite this, incarceration for drug-related offenses has increased in Brazil[9].

In recent years, due to the significant increase in crack use in Brazil, concern with the subject of illicit drugs has taken a new impulse. Decree Nº 7.179 of 2010[17] implemented the Integrated Plan to Combat Crack and other drugs, following the prevention, care and authority model. At the same time, discussions on the drug law are expanded, including the lack of objective criteria (such as the amount of drug in own possession) for the legal definition of who is a user and who is a trafficker.

Brazil - Care

Until the late 1980s, public mental health care was focused on accredited hospitals. In this period, the number of private, charitable and spontaneous services such as Therapeutic Communities and groups such as Alcoholics Anonymous increased. In the 1990s, government initiatives emerged to reduce service shortages by building a large out-of-hospital network[18], training multiprofessional teams and defining specific policies for drug-related issues[19].

This network is expanding and has different services and actions to consider the diverse universe of people who use drugs. Among the elements and actions of the network are those developed by the Primary Care Network, which involve the Primary Health Care (PHC) Facilities (including health centers and health posts), the Family Health Care Strategy (which includes Family Health Care teams and Community Health Workers), NASFs (Family Health Care Support Centers) and Street Clinics (aimed at serving people living in the streets). These devices have great access to users of alcohol and other drugs, because they serve most of the population in their territory and perform actions such as early identification, short intervention[20] and treatment of less serious cases[21].

In the case of PHC Facilities, Vargas et al.[22] states that such establishments have the characteristic of being of high turnover and a short

period of stay, hindering the team's approach for the continuity of treatment. In addition, according to Andrade[23], while expanded, the Family Health Care Strategy still has very poor population coverage, below 20% in some large cities. Low coverage impairs the territorial linkage between patients and institutions and is an overloading factor of Psychosocial Care Centers for alcohol and drugs (CAPS ad), compromising functions for which they were designed[23].

The CAPS ad play a central role in the network and are widely inserted in the orientation of deinstitutionalization of patients, seeking to maintain or reintegrate them in their communities. They seek the partnership and autonomy of patients, as well as in the construction of the therapeutic project, avoiding strict frameworks[24]. By April 2015, 308 CAPS ad had been established in Brazil[25]. However, according to Souza[26], in spite of the rich proposals for CAPS ad interventions, in practice, many of the recommended activities do not come to fruition.

Another weakness of the network of care to people with drug problems refers to its difficult access. Since many people with drug-related issues do not access social and health services and many of them live in a street situation[27], Street Clinics (SC) have emerged since 2011[28] with the aim of providing health care to users in their own life contexts. The 129 SCs[25] in Brazil have a multidisciplinary team that moves from its fixed spot to develop its care activities with drug users wherever these are.

In 2011, the units of the alcohol and drug care network included the Reception Units (RU)[29]. RUs have a transitional and voluntary residential character and aim to provide continuous care for users in situations of social and family vulnerability. By April 2015, 34 RUs had been established[25]. The most appropriate way of providing care to people with drug problems in situations that require hospitalization is under discussion[23]. The devices currently used are general hospital beds, CAPS ad III and Therapeutic Communities.

Attendance to needs not addressed by health networks is carried out through articulation with other networks (social welfare, education and justice) in an interdisciplinary / intersectoral way[30]. The Social Welfare network includes the Social Welfare Specialized Reference Centers (CREAS) – which promote access to social and welfare rights and Special Reference Centers for People Living in the Street (POP Center).

Portugal - Legislation

In Portugal, at the end of the 1990s, the government convened a committee of experts from several areas to draw up an in-depth report on the situation and at the same time to elaborate a set of recommendations for a global intervention strategy. The conclusions of this commission were the starting point for a series of legislative changes in the following years, including drug use decriminalization[31]. Thus, the first National Strategy to Combat Drugs and Drug Addiction (ENLCDT) was approved by the government[32].

As of July 2001, drug use was considered a crime punishable by up to 3 months prison or a pecuniary fine. If the amount of drugs seized exceeded three daily doses, the prison sentence could be up to one year. Drug possession was also always considered a crime and could be punishable differently depending on whether it was considered for personal use or trafficking.

The most emblematic of the measures introduced by the National Strategy was the decriminalization of use, acquisition and possession for own consumption of all psychoactive substances through the enactment of Law Nº 30/2000[33], and later, in Decree-Law Nº 130-A/2001[34]. This new law maintained the illegal status of drugs, but the punishment of its use and possession was changed. Any citizen will not be punished judicially if the use or possession of drugs is less than the equivalent of ten times the daily consumption. In order to implement this new Law, Drug Addiction Deterrence Commissions (DADC) were established, replacing the criminal courts.

DADCs consist of three members appointed by the Ministers of Health and Justice. The member appointed by the Minister of Justice is a lawyer and the other two are usually health professionals or social workers. Commissions are supported by a technical team of psychologists, sociologists or social workers and lawyers. When consumers are approached, the police keep their data, seize the illegal substance and they are then subpoenaed to appear before the Commission. If they do not show up, an administrative penalty can be imposed in their absence, such as a fine, revocation of driver's license or firearm use license, community service or a ban to go to certain places. In DADCs, the motivations for use, the consumption history, dependence issues and family and labor issues are discussed, and if justified, the referral for treatment and follow-up is made.

A summary of differences in Brazilian and Portuguese legislation is shown in Chart 1.

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Portugal – Care

The provision of treatment to drug users was virtually non-existent in Portugal before 1973[35]. Following the 1974 revolution, the Ministry of Justice established the Drug Prophylaxis Study Centers for prevention, treatment and social inclusion activities. The first treatment facility, namely, the Taipas Center emerged in Lisbon within the Ministry of Health (MS) only in 1987. Without legal support, some HR initiatives like the *STOP SIDA* Syringe Exchange Program in 1993 and the Methadone Opiate Replacement Program in 1996 were emerging.

In the 1990s and in parallel with drug use decriminalization, the network of public services for the prevention, treatment and reinsertion of drug addicts was expanded. This was in line with the ENLCDT, with the creation of the Drug Addiction Prevention and Treatment Service in the MS and subsequent approval of Law No. 7[36] in 1997. In addition, risk and harm reduction services[37] were established, such as Street Teams, Support Offices (providing minimum hygiene and food services, psychological and social support, nursing care, condoms, intravenous use tools for syringe exchange and medical and psychiatric support), Low-Threshold Requirement Opiate Replacement Programs, Reception Centers (temporary residential spaces operating on a 24/7 basis), Shelter Centers (overnight accommodations) and Contact and Information Points (services of awareness, information and listening to populations focused on prevention).

In 2004, the re-evaluation of ENLCDT resulted in the drafting of the National Plan to Combat Drugs and Drug Addiction Horizon 2012, upholding the principles of humanism and pragmatism, citizen's centrality, territoriality and integrated responses.

With the publication of the new organic law of the MS, approved by Decree-Law Nº124/2011[39], the Government created the Addictive Behaviors and Dependencies Intervention Service (SICAD) with the function of planning and monitoring use reduction and prevention programs. Prevention activities are youth-focused and coordinated by the SICAD in cooperation with the Ministry of Education and Police, as well as with state-funded NGOs. Thus, teams develop prevention activities in schools, sports centers, health centers and festive contexts. A website with information aimed at young people[40] with a toll-free telephone support line was also developed. The style of communication was deliberately indirect, promoting a healthy lifestyle and avoiding the questionable approach of aggressively condemning consumption[41]. The Safe School program consists of policing school proximities, deterring drug trafficking.

The HR target population consists of long-standing heroin and cocaine users with social and health shortcomings, who do not intend or are unable to quit and do not contact support network services, such as addiction treatment services. The state finances hostels and street teams mostly through NGOs. Street teams conduct daily visits to places where heroin users

Chart 1. Differences and similarities in drug legislation in Brazil and Portugal.

	Brazil[16]	**Portugal**[51]
Prison sentence for illicit drug trafficking	Yes up to 15 years	Yes up to 12 years
Prison sentence for drug use	No	No
Differentiation between user and trafficker	Judge's (subjective) interpretation	Amount of drug seized (≤ 10 days of use)
Type of use offense	Crime	Administrative offense
Location of administration of user sanctions	Court	Dissuasion Commissions (Ministry of Health)
Possible sanctions for users	- Warning - Community work - Attendance at an educational program - Fine	- Suspended firearms license - Professional license revoked - Prohibition of attending certain places - Fine

often gather and they distribute kits with clean needles and syringes, distilled water, gauze and a condom to consumers.

Many different structures provide care to users. This complexity reflects the troubled history of creating responses to users and results in differences in existing structures and competencies of each among different regions of the country. Currently, SICAD tries to organize and articulate all these structures, recommending an algorithm for referral divided by geographic area and by three levels of intervention according to people's risk situation assessment[42]. Defining the risk level takes into account the current pattern of drug use, risk behaviors in various spheres of individual functioning (health, sexuality, social, family) and comorbid situations.

Primary Care is involved at Intervention Level I. Specialized Health Care, such as Integrated Response Centers, Alcohology Facilities, Public Therapeutic Communities and Intensive Care Units for Smoking Cessation is involved at Intervention Level II. Level III requires the intervention of Integrated Response Centers (such as the Taipas Center in Lisbon[43]) or other Specialized Units, such as Withdrawal Facilities (short stay), Alcohology Facilities and Therapeutic Communities (long-term stay) and the Hospital Medical Surgery Specialty Services.

Re-socialization is aimed at supporting return to (or onset of) professional life[44] and data from the Algarve region (south of the country)[45] show positive results. Similar to what happens in most European countries (17 of the 21 that reported this information[46]), Portugal provides free housing available to users that is conditional on referral to treatment or its completion, which can still be considered as abstention-inspired[46]. Lisbon was one of the five European cities chosen for an EU-funded pilot project called "Housing First", not conditional on treatment and with overall positive results on the quality of life[47].

Implications of the national antidrug strategy

Adam and Raschzok[48] suggest that the change of law based on scientific evidence and the opinion of technical experts (National Antidrug Strategy Commission) in Portugal was possible because of a simultaneous great pressure of the problem with drugs (specifically, heroin), overburdened police and judicial institutions favorable to a law change and the lack of ideological beliefs against decriminalization in the ruling Socialist Party in 2001.

The drug issue and its decriminalization are not politically neutral. The ideological filter of the authors tends to add to the complexity that an analysis of the results implies and to the fact that there is no Portugal-control, that is, a country hypothetically equal to Portugal where there had been no change of law for a direct comparison. Even looking at objective data, it is impossible to see whether changes were related solely to law change and not to the rest of the reform in the care for users as well as to other factors (the Portuguese economic crisis and other globalized world trends).

In any case, more than a decade after the reform, it enjoys widespread acceptance and a positive impact on reducing the health consequences related to drug abuse[49]. We can highlight: 1) Increased number of users undergoing treatment[50]; 2) Increased consumption in adults; 3) Young people reduced use, contrary to European trend; 4) Reducing the burden on the judicial system, increasing drug seizures and trust in the police; while it is difficult to objectively assess, police opinion on the law, as well as users' on the relationship with the police has already been the target of some independent qualitative study[2,51]; 5) Reduced problematic use, illustrated by decreased new HIV infections among drug users[50] and the number of injectable drug users[50].

Discussion

The review of literature reveals that production on the repercussions of law changes for care in the two countries is scarce. Many epidemiological studies are found in both countries, but few on policy evaluation. Papers found are mainly descriptive, with critiques and personal evaluations. We found more Brazilian papers. It is also observed that there are similarities and differences between the two realities. The similarities and differences were noted regarding the context of use and concerns with this use, the historical dynamics of law changes, their repercussions on the clinic and care policy reorganization.

For example, both countries are still worried about problems related to the use of psychoactive substances, as well as with alcohol and tobacco, which are among drugs related to health the

most, use of which by young people is a matter of concern. However, growing crack use and crack use-related issues in Brazilian reality are without a parallel in Portugal. In Portugal, heroin use-related problems concerns have declined in recent years, but opioid use prevalence rates remain well above those of Brazil.

Both countries have staged a debate on treatment strategies and on the need to adapt laws. In both cases, policy change initiatives are in place to reduce the repressive approach, with the differentiation between users and traffickers, increasing the punishment of traffickers and slowing down punishment of users. However, confirming the varying approaches to the problem, in December 2017, the Brazilian government fostered a discussion at CONAD on a resolution that yet proposes a prohibitionist model with an emphasis on withdrawal. These proposed changes were not within the scope of this review; however, they were disclosed prior to the publication of this paper and include important elements for their current situation.

Portugal has more than 10 years' experience of legislation that is much less repressive and the literature review suggests that the implemented changes were articulated in order to involve Justice and health stakeholders (professionals and institutions) more comprehensively than in Brazil. We were unable to find studies on the repercussion of law change on Brazilian care.

In Portugal, there are few studies with some very favorable results and others not. Favorable outcomes of amending laws include reducing young people's use, lowering the judicial system's burden, curbing problematic use, decreasing new HIV infections and slashing the number of injectable drug users. Among the unfavorable ones are increased adult consumption (lifetime use). Regarding this last indicator, the fact that increase refers to lifetime use [according to the EMCDDA[8], of three prevalence measures, lifetime use is the blurriest (...) not reflecting the current situation of drug use] and increase follows a European trend, while Portuguese consumption is below European average[8] are mitigating factors.

Prospects

The scarce scientific production on the subject in the two countries shows the need to increase knowledge through research that effectively identifies the implications of changes in the legislation on care. To this effect, scientific literature must be complemented by the analysis of governmental documents and NGOs and articulated to the studies with the stakeholders in the field, including managers, professionals and population receiving care. Hence, the importance of research-interventions that take into account extended, participatory, networked and contextualized implementation methodologies[52]. However, what is described in literature suggests that it is necessary to advance the prevention of the use of alcohol and other drugs in both countries. Such actions must be planned for the medium- and long-term and cannot be performed to achieve immediate results, despite demand from management, professionals and population for instant responses. Changes in the legislation and in the care network operated in Brazil and Portugal, with a trend to replace a repressive approach with a public health approach may foster greater dialogue between health and justice institutions and better care to people with drug problems in both countries.

Collaborations

RO Mendes: literature review on the epidemiology of drug use in Brazil, article review. PB Pacheco: literature review on legislation in Brazil. JPCOV Nunes: literature review on care in Portugal. PS Crespo: literature review on legislation in Portugal. MS Cruz: conception, method and review about assistance in Brazil. All authors participated in the discussion and effectively in the writing of the article.

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Article submitted 29/01/2017
Approved 29/01/2018
Final version submitted 31/01/2018