

“In the middle of the crossfire”: considerations about the armed violence impacts in Primary Health Care in the city of Rio de Janeiro

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Abstract *The paper addresses the impacts of armed violence, based on Primary Health Care, in a neighborhood in the city of Rio de Janeiro, Brazil. This is a qualitative exploratory study developed in two services aiming to identify the main types of violence, their impacts and the strategies used to cope with the phenomenon. The production of information included data collection in the service records, conducting semi-structured interviews, focus groups and feedback seminar. Armed violence, among all expressions of violence, was identified as one of the major concerns of healthcare professionals and users of services, due to its intense occurrence and the severity of its consequences on health. Its impact on strategies to cope with the violence and the difficulty in making the phenomenon visible are highlighted. It is considered that this type of violence, prevalent in the black territories of the city, is legitimized by structural racism, being the public security policy – based on the ideal of war on drugs and on the military confrontation with armed groups that operate in the retail trade of illicit drugs – expressions of state racism and necropolitics.*

Key words *Gun violence, Health, Violence, Primary Health Care, Drug Laws*

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Introduction

The paper seeks to reflect on the impacts of armed violence (AV) on Primary Health Care (PHC) in a neighborhood located in the northern zone of the city of Rio de Janeiro. It has public and private institutions and its 36,160¹ inhabitants live in a slum complex. To get an idea of the size, 4,629 Brazilian municipalities, out of a total of 5,570, are less populous than this location². The Social Development Index (SDI), an indicator that gathers data on sanitation, housing, education and income, is one of the worst in the city, with the neighborhood almost at the end of the list of 161 neighborhoods¹. Data for the year 2016 from the Mortality Information System (SIM, *Sistema de Informação de Mortalidade*) of the Ministry of Health (MS, *Ministério da Saúde*) show that 39% of local deaths from external causes were related to AV, while the city of Rio de Janeiro had a percentage of 22%.

The fieldwork that gave rise to this article sought to identify the main types of violence that affect the place, its impacts on health and the strategies used to produce care and cope with the phenomenon³. The text prioritizes the discussion about the main expression of violence found – the AV – and discusses its consequences on the services and the health of professionals and users.

In the surveyed place there is a strong presence of armed groups with dominion over the territory⁴⁻⁶ who carry out illegal activities, including the illegal drug trade. These groups are the target of operations by the police forces, which are based on public security policy anchored in the ideology of war on drugs^{7,8} and in the warlike confrontation of the illegal drug retail aimed at its elimination and a “drug-free” society.

Zaluar⁹ points out that the policies to repress drug trafficking have imprinted the dialectic of corruption/business maintenance/abuse of the police force/violation of rights. This type of repression, combined with the authoritarian forms of power practiced by criminal gangs, results in the fear and silence of the population and the use of weapons as a way of resolving conflicts. Gomes-Medeiros et al.¹⁰ underline the association between prohibitionist policies, increased violence and mortality from homicide, which is the most dramatic consequence of the so-called war on drugs. Its main target is the male, young, black population with low education level¹¹, since it is undertaken, mainly, in spaces of social vulnerability of the city, whose population is, in its majority, black¹². It affects everyone who lives

there and, to a lesser extent, also those who work there.

This fact expresses intersectionality related to race, class and spatial location, which can be better understood if we consider the structural aspect of racism¹³, a fundamental component of the economic, political and legal inequality that marks Brazilian society. Racial classifications were central to the legitimacy of colonial relations^{14,15}, the enslavement of Africans and the liberation process without reparation or social inclusion¹⁶, historical milestones that express how structural racism is at the heart of the construction of Brazilian society. The racialized hierarchies built from this process remain and maintain, even today, the black population in a position of vulnerability, inhabiting spaces that are the target of armed violence and a militarized and offensive public security policy that violate human rights daily.

In Rio de Janeiro, most of the PHC services are located in areas with characteristics and contexts similar to the case studied. In some territories, in addition to the clashes between armed groups and security forces, there are also disputes between different armed groups, which rival the monopoly of the retail illegal drug trade, which aggravates AV. PHC is the most basic level of the Unified Healthcare System (SUS, *Sistema Único de Saúde*), has a territorial organization and serves a restricted population, which makes the impacts of AV very noticeable at this level of care.

In Brazil, the organization of the healthcare system, regarding the problem of violence, is linked to the perception of its impacts on the population's morbidity and mortality profile. As Minayo et al.¹⁷ remind us, violence affects individual and collective health, causes deaths, injuries and traumas, decreases quality of life, poses challenges for healthcare services and highlights the need for interdisciplinary, intersectoral and socially engaged action.

The healthcare sector is called upon to build responses to tackle violence in terms of health care, surveillance, prevention and promotion¹⁸. In 1975, the Mortality Information System (SIM) was created, which is central to understanding mortality from violence in the country. In 2001, the National Policy for the Reduction of Morbidity and Mortality from Accidents and Violence (PNRMMAV, *Política Nacional de Redução da Morbimortalidade por Acidentes e Violências*)¹⁹ was enacted by the Ministry of Health, which incorporates the topic as a public health issue and establishes guidelines for its confrontation.

The National Health Promotion Policy (PNPS, *Política Nacional de Promoção da Saúde*)²⁰, in 2006, establishes the reduction of violence as a priority and highlights the encouragement of networking, with emphasis on the implementation of the interpersonal violence notification form. In 2011, MS²¹ includes violence as a condition of compulsory notification, implying the standardization of procedures and flows for epidemiological surveillance. It is up to every health professional to notify cases by registering them in the Notifiable Diseases Information System (SINAN, *Sistema de Informação de Agravos de Notificação*), being mandatory for:

*Suspected or confirmed case of domestic/intra-family, sexual, self-inflicted violence, human trafficking, slave labor, child labor, torture, legal intervention and homophobic violence against women and men at all ages. In the case of extra-family/community violence, only violence against children, adolescents, women, the elderly, persons with disabilities, indigenous people and the LGBT population will be notified.*²²(p.21)

However, there are several challenges in healthcare services to carry out this action, with significant underreporting^{23,24}. Violence implies permanent and complex challenges, as it expresses violations of rights that are difficult to resolve and with consequences that unfold in various areas of people's lives.

PHC services are essential in identifying and welcoming cases of violence due to their proximity to the population and the potential to develop coping strategies. The services are based on the bond between professional and user, which facilitates the identification of injuries and the development of care, protection and harm reduction actions²⁵. However, although there is this important historical path, AV is not, until now, the focus of confrontation by PHC.

We define AV as real violence, or threatened, with the use of a gun, which includes a series of expressions such as shootings, "stray bullets", sniper action, overt exposure and use of weapons, grenades, bombs and other types of explosives, etc. AV affects individuals and institutions and impacts on people's health and social actions in the territory. The PHC services have their routine changed and there are effects on the workers' health, which has repercussions on the attention given to the population.

Methodology

The study followed the ethical requirements related to research advocated by the National Commission for Ethics in Research. The participants were not identified and, in the statements cited in this paper, the professional categories were omitted, in order to guarantee the principles of anonymity and confidentiality. The project was approved by CEP/ENSP.

The data were collected from qualitative exploratory research of the case study type, which aimed to identify, from two PHC services, the main types of violence present at the site, their impacts and the strategies used to cope with them and to produce care. The fieldwork, developed in 2016, included the following steps:

(1) Collection of information on cases of violence registered in the services, in a sample of three months (October to December 2015). Using a recording instrument, we sought to understand the types and natures of violence, affected groups, referrals, outcomes and health problems related. There were 226 physical records, 20 electronic files, 3 forms of compulsory notification of violence and 50 forms of psychology reception. A filter was applied regarding the care provided by geriatricians, pediatricians, psychiatrists, psychologists and social workers, based on the orientation of the services regarding the internal referral flow of cases of violence.

(2) Semi-structured interviews (six) with service workers representing areas indicated by the service management as important for the care related to violence: management, community therapy, social service, psychology and institutional articulation. The script sought to understand the types of violence present in the territory, affected groups, impacts on the service and the health of professionals and users, training, coping strategies and contact with the protection network.

(3) Focus groups (four), which brought together 40 people indicated by the services management as important for the care related to violence: community health agents, doctors, nurses, nursing technicians, professionals from the Family Health Support Center (NASF, *Núcleo de Apoio à Saúde da Família*) and residents participating in local health councils. The script sought to understand the types of violence present in the territory, affected groups, impacts on the service

and the health of professionals and users, training, coping strategies and contact with the protection network.

(4) Conducting a seminar to present the results of the research to the PHC services and partners in the intersectoral network of care and social protection for people in situations of violence. The table comprised representatives of the Programming Area Coordination of the Municipal Health Department (CAP [Coordenadoria da Área Programática] 3.1/SMS [Secretaria Municipal de Saúde]), of the Special Reference Center for Social Assistance (CREAS, *Centro de Referência Especial de Assistência Social*) and of the Child Care Council (CT, *Conselho Tutelar*), who were able to report their experiences related to the research results, enriching the perspective of analysis from the partners of the protection network.

To handle the information in step 1, a simple descriptive analysis was adopted; for steps 2 and 3, the thematic content analysis principles^{26,27} were followed: in the pre-analysis there was a fluctuating reading based on the main aspects addressed in the scripts and the constitution of the analysis corpus; in the material exploration phase, the categories of meaning were raised, based on the classification of the main topics covered, followed by the organization of information; in the third phase, the results were analyzed and critically interpreted in the light of the literature. The record of the discussions in step 4 was used in a complementary way to the analyzes undertaken here. In this paper, the discussion about AV was prioritized due to the pregnancy of its presence in the results of the fieldwork.

Results

AV impacts on the health of professionals and users and on services

AV, among all expressions of violence, was identified as one of the biggest concerns of health professionals and users of PHC services due to its intense occurrence. Serious results are recorded as intentional homicides or due to “stray bullets”; witness of torture and homicide; involvement of family and friends with armed groups in the illicit drug retail trade; invasion of homes by people linked to armed groups – the so-called traffickers – imposing the guard of arms; invasion of homes by security forces in search of drugs, weapons and people involved in trafficking; invasion of public services by police and traffickers in search

of people; expulsion of residents from the territory by armed groups; violence against women whose partners belong to criminal gangs, especially related to threats with guns.

As is already known, there is a synchrony between the most overt, the most subtle and the most private violences¹⁷. The reports show an intersection of the AV with a series of other expressions, such as the intrafamily, which involves physical and verbal aggressions, sexual abuse and neglect of different orders. The occurrence of self-inflicted violence is also significant, with suicidal attempts and ideations, and in the latter case, the practice of self-harm among young people.

AV demonstrations violate basic rights, healthcare services have to partially or totally close down and suspend community activities to reduce the risks to the lives of workers and users. The operations of the security forces are mostly carried out in an ostensible and violent manner. It is not uncommon to register the arrival of the police in the favela shooting through guns, which leaves the local population vulnerable and produces injuries and deaths. At such times, feelings of insecurity grow, which generate fear among all people.

There is structural precariousness in some local healthcare services, such as those built in fragile containers, which represents an increase in the vulnerability already experienced in coming and going. In addition to the risks of injury and death, professionals and residents accumulate illnesses arising from the experience of AV or intensified by it:

Yesterday there was a shootout, the whole clinic went to the middle of the corridor, but there is no refuge here [we work in the containers]. A bullet came in, if someone had been there [they would have died]. The mental health of the staff is really affected! (Healthcare professional).

The testimonies highlight the development or worsening of symptoms related to gastritis, ulcers, lack of glycemic control and hypertension. As an immediate reaction to the events, vomiting, diarrhea in children and bleeding in pregnant women were reported. In relation to mental health, anxiety, insomnia, stress, mood changes, intense diffuse psychological suffering, relationship difficulties and fear of leaving the house were registered, in addition to more severe conditions such as panic attacks, phobias, depression and worsening of the psychotic condition:

I was at the reception and a young black boy, who was monitoring blood pressure, arrived. Ex-

hausted and nervous, he had been searched because it was having a police foray and he was trying to get to the clinic. When he was leaving the house, the police wanted to come in and searched everything, he thought it was too much and went to the UPP (Pacifying Police Unit [Unidade de Polícia Pacificadora]) to complain, and there they slapped him in the face. The blood pressure that was already high, got higher, he had to [receive] medication. Two days later, the doctor had to administer medicine, because he was diagnosed with hypertension (Health professional).

In the medical records of users, the note of psychopathological conditions associated with AV is noteworthy. The most registered codes of the International Classification of Diseases (ICD 10) are those of Chapter V, on “Mental and Behavioral Disorders”: “F48.9 Unspecified neurotic disorder”, “F41.0 Panic Disorder”, “F41.1 Generalized anxiety”, “F31.9 Unspecified bipolar affective disorder”, and “F13.2 Mental and behavioral disorders due to the use of sedatives and hypnotics - dependency syndrome”.

On the part of professionals, there are reports of sick leave from work as one of the impacts of AV. Among them, the Community Health Agents (CHA) are the most exposed, because, in addition to being workers, they are residents of the territory:

We see violence daily. You get stressed. How are you going to work in an area of violence, with shootings, with police, with criminals? How do you leave home? You don't know if you're going, you don't know if you're staying, and it's a serious problem! A lot of people are sick! (Healthcare professional)

The severity of the cases treated, difficulties in referring and solving problems, as well as the proximity to the social vulnerability of users due to the bond that characterizes the professional / user relationship in PHC, distress professionals and are suffering factors. However, the ability for resilience identified among users in coping with adverse life situations, provides professionals with some encouragement.

Difficulties and limits of compulsory notification of violence

The notification of violence is an instrument of epidemiological surveillance to report suspected or confirmed cases to the health authority, aiming to cope with this problem. Despite its importance, this notification is deficient in the researched territory, which is not a local exclusivity.

Professionals attribute this fact to the extension of the file, work overload, fear of retaliations by armed groups with dominion over the territory, fear of a weakened bond with families, with consequent abandonment of the work and worsening of the situation of violence.

Notification is an act of the healthcare sector that aims to the protection; however, in a territory with significant occupation of armed groups and intense confrontations by guns, PHC professionals fear that, when they comply with the guidance of health surveillance, they are exposing themselves to anger of these groups. Above all, CHAs express this fear, insofar as they know and are known in their workplace and home. Another factor is the confusion that many professionals make between notification and complaint. The act of notifying refers to the healthcare sector and generates information about violence. Its insertion in SINAN is the result of the struggle of generations of professionals and social movements to generate visibility on the violence. The complaint refers to the public security and justice bodies, and can be made by anyone. The situation, as it appears, makes it difficult to consolidate notification as a routine service practice. During the research period, only three notifications of violence were registered, a number disproportionate to the cases narrated in interviews and medical records:

Violence is on display, you see it, but, what can you do? This woman who was beaten, with her face all broken, said that she had fallen. Her husband was working for the illegal drug trade, then she will tell me and I will tell the doctor and I will take sides. And what does he do to me afterwards, in the territory? (Healthcare professional)

However, the non-notification of the situation of violence by the PHC does not prevent the cases from being brought to the attention of the health authorities, as other healthcare services, such as emergencies, can register when attending to the population, already in a much more serious care situation. CAP 3.1 / SMS, which receives notifications and monitors cases, periodically returns to PHC units reports with cases in its area of coverage, since it is up to these units to monitor them.

Networking in care and social protection for people in situation of violence

For care to violence and health, intrasectoral networking is essential, bringing together other healthcare services; and intersectoral, articulat-

ing with services such as social assistance, education and NGOs. In this study, a better functioning of the intrasectoral healthcare network was identified, with an effort to follow up and referrals among the different levels of care. The main partners of the intrasectoral network mentioned were the Programmatic Area Coordination of the Municipal Health Secretariat (CAP 3.1/SMS) and the Psychosocial Care Center (CAPS, *Centro de Atenção Psicossocial*).

Regarding referrals to the intersectoral network, PHC professionals reported difficulties, as they perceive it as overburdened by the lack of professionals and logistical difficulties. These are related to the lack of adequate investment for the consolidation and development of activities, which affects the effectiveness of referrals and communication. The main partners of the intersectoral network mentioned were: Child Care Council (CT), Specialized Reference Center for Social Assistance (CREAS), Reference Center for Social Assistance (CRAS) and Regional Education Coordination (CRE).

In general, cases that could be addressed in an intersectoral way, end up being treated only from the healthcare perspective, which has a greater number of available professionals in the area, compared to other services²⁸. Referrals to the protection network are precarious and happen almost exclusively in extreme cases. Another issue is that referral to the intersectoral network requires follow-up time; however, this work is not counted in the goals of the healthcare service, which discourages professionals from doing so, as they are usually overwhelmed with other demands.

Professionals consider the referral process to other services and the return to health confusing, with considerable difficulties in accessing information when it comes to monitoring cases. One reason is that each sector uses a different information system, with no standardization for this intersectoral communication, nor for the flow of referrals between services. Improving communication was seen as a major challenge by everyone.

Network partners also demand health actions because, despite the difficulties, PHC services develop care strategies to minimize the effects of violence and strengthen bonds. Several times, the search for specialized services, such as psychologists and psychiatrists in cases of psychological suffering, generates referrals to the health institution to which these services are bound. PHC bets on the bond and proximity to families to ensure longitudinal care and a multidisciplinary team,

guaranteeing access to resources available in the sector.

During the seminar held, there was a consensus among the different components of the protection network on the negative impacts of AV: fear, feeling of helplessness, physical and mental illness of workers and difficulty in circulating through the territory impair the integration between the different services. The problems experienced in healthcare are shared by other sectors:

It changes the routine, the tension, increases stress and concern for the professional on the street. There has already been a case of a professional visiting and the policeman pointing the gun to him/her because the person was black and had no vest, he/she was just wearing a blouse and a healthcare professional's badge (Healthcare professional).

Discussion

Based on the analysis of the results, it is considered that the phenomenon of violence in general, and of AV in particular, is extremely relevant in the context studied, unfolding into impacts on the physical and mental health of professionals and users and on the functioning of the services.

These expressions of violence cannot be decontextualized from the prevalence of structural violence that cuts across Brazilian society and maintains inequalities. This violence, considered “natural”, affects the living conditions of the population and is historically related to the Brazilian political, cultural, economic and social structure²⁹, making itself present, in a dramatic way, in the most devalued living spaces in cities, like Rio's favelas.

It is to these spaces that the repressive arm of the Brazilian public security policy is directed, guided by the ideals of war on drugs. Such a policy bets on the ostensibility of warlike power, prioritizing repression operations to the detriment of intelligence actions^{30,31}. However, when entering the favela to fight yet another battle against drugs, the security forces find another actor who is also heavily armed: groups with dominion over territory. It is not uncommon to identify in the reports of professionals and residents the feeling of being “in the crossfire”, “cornered”. Regardless of who shoots, they will be hit.

The complex scenario of the drug war policy in Latin America and Brazil^{32,33} and the international illegal arms and drugs trade^{34,35} sustain the violence that is practiced daily in the favelas, where the poorest part of the population lives,

mostly black people. Racial violence³⁶, which turns to black bodies, makes them the main recipients of violence and is reflected in the high mortality rates from external causes, much higher than that of non-black people. Michel Foucault³⁷ already pointed out that State racism is a fundamental part of the exercise of power in modern times, creating and hierarchizing races, differentiating groups and informing who should live and who can die. From this author, Mbembe³⁸ coined the concept of necropolitics, in order to think about contemporary ways of submitting life to death technologies, arranged with the aim of causing the destruction of people, submitting entire populations. These concepts help us to understand policies such as that of Brazilian public security carried out in favelas and that leave the black population much more exposed to death and extermination, reifying it as a target of the State's death power. Social permissiveness is also added, in view of the development of violent actions that harm human rights, in precarious and stigmatized spaces as dangerous. The consequences of such a policy on the lives and health of professionals and residents are profound, as highlighted in the research.

The difficulties of healthcare professionals in dealing with situations that involve violence were also identified by other studies, which highlight the challenges of attending cases due to lack of knowledge about the types and natures of violence³⁹⁻⁴¹; the problems to properly record the facts⁴²; the confusion between notification and complaint^{24,43-45}; and the feeling of helplessness and psychic suffering^{44,46}. It is considered that the violent action of armed groups with domain of the territory and the existence of an autocratic system of justice, in this case, aggravate the difficulties listed above. The consequences of the notification, in the professionals' imagination, are perceived as police acts that can reveal violence related to other illegalities, such as drug trafficking, arms trafficking and robberies. Thus, an act of care that would hypothetically aim to break the cycle of violence is omitted.

Studies indicate the lack of knowledge or even interest of healthcare professionals about how the social protection network and its services⁴⁵ work, making it difficult to provide comprehensive care to people who experience violence. In addition, in Rio de Janeiro, the current scenario of precarious network services generates more uncertainties than the effectiveness of the actions. According to reports, the referral flow is difficult because the services are overloaded, which is attributed

to the financial and political problems of the state and the municipality. Furthermore, the AV scenario, common to many territories where the network services operate, makes professionals question whether the risk of exposure is worth it, without guaranteeing a solution for the cases and without the effective support to solve them by the local authorities.

This situation is one of the examples of how AV collaborates with the invisibility of cases of violence in Rio de Janeiro: if not reported, they do not exist for information systems. Thus, its consequences are not a priority demand for public action. Although the figures related to violence at SINAN are already striking, it can be inferred, with support in the literature^{23,24} and in the field-work, that there is considerable under-registration. In its turn, underreporting corroborates the institutional weakening of the intersectoral network, as it makes it appear falsely that there is no demand and that public investment is unnecessary. In view of the complexity of the problematic notification/underreporting, it is necessary to listen to the professionals and consider the difficulties of local realities, in order to develop strategies that can value and give meaning to this instrument, such as its review and application regulations.

Another point related to the invisibility of AV is that, despite the enormous relevance in the research results and the related morbidity and mortality, there is no record of this violence in SINAN between 2016 and 2018 (last year available) for the studied territory. However, it is known that the occurrence of AV on the location is enormous. As a reaction to this invisibility and as a means of denouncing violence, organized civil society has made efforts to produce information. One of the initiatives is the *Fogo Cruzado* collaborative platform, which shows risks related to circulation during episodes of AV and which began collecting data in the second half of 2016, accounting for 22 shootings in the neighborhood in that period alone; in 2017 there were 79, and in 2018, 77.

It is also worth mentioning the implementation of *Acesso Mais Seguro* initiative, a partnership between the International Committee of the Red Cross and the SMS of Rio de Janeiro. This entity, which develops actions in conflicted places, in situations of war, has been present in Rio de Janeiro since 2009, operating in territories with high AV rates. This initiative aims to develop strategies to protect PHC health professionals, through the development of a contin-

gency plan, action protocol and record related to changes in the functioning of services due to AV. The fieldwork, carried out in 2016, coincided with the implementation of this initiative in the territory. Despite having important information about changing the routine of services, due to the occurrence of AV, this bank is not public and its data are not available.

Final considerations

Regarding the attention focused on the manifestations of interpersonal violence, it is considered that the services that make up the PHC in the studied territory are able to welcome people, strengthen bonds and produce care, despite the underreporting of such violence. However, in relation to AV, there are enormous challenges both to break its invisibility and to structure more effective actions.

Health literature has little to do with the phenomenon and timidly records AV damage to the people's health. Information is essential to guide effective public policies and committed to people's needs, their absence deepens the vulnerability and risk of those who live and work in favelas, where public security policy is exercised almost exclusively through the state-owned repressive and warlike arm.

It is worth reflecting on the possibility of including, in the Compulsory Notification of Violence

Form, a specific field for the registration of people victims of AV, in addition to those who die and whose information is recorded in the SIM, in order to produce visibility for the various consequences of this phenomenon so present and dramatic in many spaces of the city. How to propose intervention for a problem of which the magnitude is not known? The healthcare sector has a good information system and has great potential to be a protagonist in this process. It is noteworthy that, however, without actively and purposefully facing underreporting, there is a considerable risk that inserting a new field in the form will not have the intended effect, i.e., being able to register the AV scenario.

AV creates an environment of insecurity and fear, weakens bonds, results in great psychological distress and inhibits the quality of public services, representing a major challenge to the guarantees of the democratic rule of law. This study, of a localized case – which has limits and cannot be generalized –, serves as a hypothesis for many other vulnerable territories in Rio de Janeiro, who daily experience in their sociability spaces the plot among structural, racial and armed violence and various expressions of interpersonal and community violence. Unfortunately, in Brazil, a country marked by enormous social, racial, gender and age inequalities, the populations of territories such as those in this study still need to conquer basic rights, such as life and to come and go.

Collaborations

MM Silva worked on the conception, collection, analysis and interpretation of data, design, writing, critical review and approval of the version to be published. FML Ribeiro worked on data collection, analysis and interpretation, design, writing, critical review and approval of the version to be published. VC Frossard worked on data interpretation, design, writing, critical review and approval of the version to be published. RM Souza worked on data collection and analysis, design, critical review and approval of the version to be published. M Schenker worked on data analysis and interpretation, critical review and approval of the version to be published. MCS Minayo worked on the design, critical review and approval of the version to be published.

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