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ORIGINAL ARTICLE

Contingency plans and state coordination in the COVID-19 pandemic

Planos de contingência e coordenação estadual do SUS na pandemia de covid-19

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DOI: 10.1590/2358-289820241429229I

ABSTRACT The article analyzes the role of the states in coordinating the response of the Unified Health System (SUS) to the COVID-19 pandemic. This documentary research was based on the 26 state contingency plans published between February 2020 and October 2021. The state governments acted in most dimensions analyzed: health emergency coordination, federative articulation, regulation, technical support, communication, integrated planning, service provision, financing, and cooperation. The results suggest the leading role of state governments in SUS management, emphasizing the search for integration, alignment, and cooperation between the sectors involved, besides decision-making based on scientific guidance and evidence. In a context of polarization and federative dispute, the state experience valued federative autonomy, a cooperative stance, and the institutional capacities in the SUS.

KEYWORDS Health policy. Contingency plans. Unified Health System. COVID-19.

RESUMO *O artigo analisa a atuação dos estados na coordenação da resposta do Sistema Único de Saúde (SUS) à pandemia de covid-19. Trata-se de pesquisa documental tendo como fonte os 26 planos de contingência estadual, publicados entre fevereiro de 2020 e outubro de 2021. Os governos estaduais atuaram na maioria das dimensões analisadas: coordenação da emergência sanitária, articulação federativa, regulação, apoio técnico, comunicação, planejamento integrado, prestação de serviços, financiamento e cooperação. Os resultados sugerem o protagonismo dos governos estaduais no plano da gestão do SUS, com destaque para a busca de integração, alinhamento e cooperação entre os setores implicados, assim como para a tomada de decisões baseada em orientações e evidências científicas. Num contexto de polarização e disputa federativa, a experiência estadual valorizou a autonomia federativa, o caráter cooperativo e as capacidades institucionais no SUS.*

PALAVRAS-CHAVE *Política de saúde. Planos de contingência. Sistema Único de Saúde. Covid-19.*

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Introduction

The debate on public policy coordination gained prominence during the COVID-19 pandemic. Comparative analyses have identified characteristics, determinants, and lessons learned from different national responses[1-5]. Such studies suggest the existence of specific factors that influenced the most successful experiences, such as solid state and political leadership capacities in national response coordination[3].

The literature has also addressed the implications of coordination on federative performance. Responding to the health and economic crises that resulted from the pandemic required interventions from all government levels. The nations with the best results developed more robust mechanisms of intergovernmental coordination and cooperation[1]. Thus, we should analyze the interactions and roles of subnational spheres to understand the coordinated response to the pandemic in federative contexts.

The literature on public policy coordination presents the concept broadly, defining it as a fundamental dimension of government action. It involves coordinating and directing organizations of diverse natures to achieve common goals to produce coherent and integrated services, streamline resources, eliminate duplications, and satisfy users[6-8].

In Brazil, the fragile national coordination and the relationships established between the federal Executive Branch and subnational entities have been documented, pointing to intergovernmental disputes and conflicts[9]. The conditioning factors include, on the one hand, strengthening the neoliberal agenda and the changes in the role played by the Presidency and the Ministry of Health, and their consequences for the rupture of the previous arrangement of federative coordination of the Unified Health System (SUS)[10,11]. On the other, the State coordination crisis during the pandemic is interpreted as a product of the federative system's characteristics, socio-spatial inequalities, and the escalated political tensions between governments[12].

Studies targeting state governments emphasize political conflicts with the federal Executive Branch and their implications for responding to the pandemic[13,14]. Other studies address state policies on social distancing and the implementation of non-pharmacological interventions[15], the role of interstate consortia[16], and the fiscal situation[17]. These studies share the importance of governors, joint action, and the state governments' response speed, considering the set of public policies.

In particular, works that address the state response in health policy emphasize specificities of certain areas or the actions of some governments[18-20], leaving gaps in understanding how the state management of the SUS coordinated policies and actions on a national and comprehensive basis.

We understand that coordination is a priority function in health emergencies and that the contingency plan is the central instrument for preparedness and response. COVID-19 contingency plans are public documents that contain health policy guidelines in different territorial contexts. As the World Health Organization (WHO) highlights, they reflect the diversity of local and regional realities and express efforts to coordinate between different actors in formulating and implementing pandemic control measures and communicating with society[21]. This article analyzes state contingency plans for COVID-19, characterizing how state SUS managers coordinated the response to the pandemic.

State SUS management competencies in coordinating health emergencies

The 1988 Federal Constitution inaugurated a new phase in Brazilian federative relationships, adopting a cooperative model for managing health policy. This proposal changed the distribution of powers between government spheres and reinforced the role

of municipalities in health policy[22]. The role of states also changed significantly, emphasizing regional planning, management, and the provision of specialized care services[23].

A particular political-institutional arrangement was formed over the first decades of the SUS with the foundations established. Brazilian federalism moved toward centralizing political and regulatory authority at the federal level, sustaining broad legislative competency, mainly regarding defining national policies to the detriment of the complete autonomy of the other spheres[24]. The federal government has historically been central to federative relationships, controlling the decision-making process and implementing specific policies[25,26].

Despite the Federal Government's leading role in coordinating social policies, subnational governments did not act as mere reproducers of national policy since the division of powers in the federation coexists with several power centers, albeit with unequal capacities[27]. Furthermore, subnational spheres have their scope for action, especially in the implementation process. Thus, the Federal Government began recognizing the need to establish a negotiation culture, seeking legitimacy with subnational governments to implement the health policy. The institutionalized spaces for inter-managerial negotiation – with representation from the three government spheres (national level) and the state and municipal spheres (state level) – played a fundamental role, making the SUS experience one of the most advanced in terms of inter-federative coordination[28]. Despite this, the literature that addresses the role of states identifies several impasses in implementing their functions[23].

We understand that the current rules do not prevent states from acting in policies such as health, education and welfare, but they do not induce them to comply with their responsibilities[29]. The institutional and fiscal design after the 1988 Federal Constitution influenced the relatively low participation of states in the governance of social policies. In practice, they were 'bypassed' by the Federal Government, a process facilitated by universal policies and the lack of party alignment between elected presidents and governors[30].

Lima et al.[23] analyzed the competencies and responsibilities of state governments in regulating the SUS based on the functions of policy formulation and planning, financing, regulation, and service provision. They emphasize that the prioritization of decentralization with a municipalist nature and the late nature of regionalization, which demands greater state leadership, impacted the performance of coordination by the states, whose role remained nonspecific and restricted to some areas.

In emergencies, public calamities, or epidemics, the three spheres, within their respective administrative scopes, must respond and plan actions and may request private goods and services, as established in Law Nº 8.080/1990. The Ministry of Health must support the federated entities, and the Health Surveillance Secretariat is responsible for coordinating the preparation and response of actions in public health emergencies of national and international concern with international health authorities, such as the WHO.

The first of the nine pillars outlined in the WHO's COVID-19 Strategic Preparedness and Response Plan[21] – an international reference document for countries' operational planning – is 'national coordination, planning, and monitoring'. Based on this document, countries were advised to develop contingency plans or adapt their influenza plans.

This first pillar includes measures such as establishing mechanisms for managing and coordinating health emergencies, involving relevant authorities and levels of government; defining the response by transmission scenario and level of government; implementing actions to contain virus transmission; mitigating social and economic consequences; establishing an updated information platform and assertive communication with affected populations; and ensuring logistics, equipment, trained staff, and designated spokespersons. These

are examples of initiatives to be taken within the scope of coordinating the health response, expressed in national and local contingency plans.

The first version of the National COVID-19 Contingency Plan[31] was published as an annex to the Epidemiological Bulletin of the Ministry of Health in February 2020. It recommended that state and municipal health secretariats develop their respective contingency plans. However, the lack of political alignment at the national level prevented the integration of stakeholders and the coordinated response, especially in early 2020.

In contrast, the initiatives of the national councils of municipal and State health secretariats (CONASEMS and CONASS, respectively) and the Pan American Health Organization (PAHO) were notable during the period, and the publication of the 'Guidelines for Confronting the Pandemic'[32] was a highlight. This material was initially published in May 2020, and only a year later, in the fourth edition, the Ministry of Health began to be listed as the author. Even burdened by the pressure and crises created by the pandemic, state and municipal managers responded to COVID-19 within their administrative spheres and through national representations. Based on this framework, this article prioritized the analysis of the different dimensions of state coordination of the SUS expressed in the COVID-19 contingency plans.

Material and methods

This exploratory study was based on documentary research[33] that used state contingency plans for COVID-19 as a source. Documents allow reconstructing experienced processes, as they portray the period and the available knowledge and are relevant for policy analysis. In the case of this research, they are fundamental instruments for understanding how state SUS management levels coordinated actions in response to COVID-19.

A preliminary critical examination of the plans was conducted in the first stage of the analysis, considering the elements of context, authors, authenticity, reliability, nature, key concepts, and the text's internal logic. The contingency plans of the twenty-six states published between February 2020 and October 2021 were selected to ensure representativeness. Considering authenticity and reliability, we collected the final versions of the plans available for public access on the official websites of the state health secretariats and the Ministry of Health. In states with more than one edition of the plan, the most recent one within the study period was considered since the plans with the most updates presented more information. The Federal District was omitted because it did not have intergovernmental relationships with the municipalities.

Because they are planning instruments that adapt to different political and institutional realities and the dynamics of the pandemic, the structure and content of the contingency plans differed – for example, the frequency with which the plans were updated varied in each State. Twenty of the 26 selected plans reported being updated, and we could find plans with up to 15 updates. Such adjustments were justified by considering the incorporation of new knowledge and protocols on COVID-19 and the epidemiological and healthcare situation in the State.

After the preliminary analysis, we sought to 'gather all the parts'[33], linking them with the theoretical elements and the study problem to interpret the results. *Table 1* was prepared to guide the grouping and analysis of the information based on references that address the role of the state sphere in health policy[23,29], the national guidelines for states and municipalities to address COVID-19[32], and the WHO guidelines for operational planning[21].

The plans were read three times, and each reading allowed for a stage of the analysis. The first reading allowed for the collection and systematization of the general information in the plans. The second reading allowed for

categorization, and the third allowed for the interpretation of the categorizations, resulting in the description of the actions found by dimension and the creation of a table with the evidence for each State. The same author conducted the stages of reading, collection, and systematization of the material.

Table 1. State SUS coordination dimensions and actions in response to COVID-19

Dimensions	Actions
Health emergency coordination	a) Structuring of emergency operations centers, crisis committees or equivalent, exclusive to the health sector or intersectoral, deliberative or consultative, with leadership from the state health secretariat. b) Composition of crisis committees or cabinets within the state government. c) Integration with SUS social control. d) Recognition of the state's role in coordination.
Federative coordination	a) Participation of representatives of the state councils of municipal health secretariats (COSEMS) in technical groups and crisis committees. b) Coordination with COSEMS, widely mentioned. c) COSEMS' contribution in preparing the contingency plan. d) Discussion and agreement on measures in SUS deliberative forums. e) Emphasis on the joint action of the three government spheres.
Regulation	a) Guidance for state regulatory centers and the services involved. b) Definition of access flows to SUS services and dissemination of information about the available care network. c) Use of specific tools and information systems for regulation. d) Use of tools to calculate the need for beds. e) Groups for managing COVID-19 beds. f) Regulatory experiences with border countries.
Technical support	a) Advice and guidance to municipal technicians and managers in response to the pandemic. b) Conducting technical visits. c) Training offerings. d) Educational activities in partnership with educational institutions. e) Activities of regional units of state health secretariats. f) Activities of institutional supporters. g) Use of proprietary information systems or tools for monitoring COVID-19. h) Preparation of summaries, translation and synthesis of findings of scientific articles.
Communication	a) Provision of electronic pages and panels for transparency of actions. b) Offering of means of communication, such as telephone lines, messaging applications, service desks, and call centers. c) Use of institutional social media. d) Partnerships with the local press. e) Communication measures with municipalities. f) Publication of reliable websites. g) Monitoring of media and fake news. h) Publication of indicator results on platforms. i) Alignment between the communication departments of the agencies involved.
Integrated planning	a) Planning of actions considering the installed capacity and epidemiological situation. b) Planning of actions considering the regional design. c) Support and provision of guiding materials for the preparation of municipal plans. d) Presentation of the state contingency plan as a guide for municipal plans. e) Reference to coordination with municipal managers in the implementation of plans. f) Monitoring of municipal plans. g) Preparation of contingency plans by health macro-region. h) Alignment between the state plan and municipal contingency plans.

Table 1. State SUS coordination dimensions and actions in response to COVID-19

Dimensions	Actions
Service provision	a) Operation of health services under state management, such as strategic information centers for health surveillance, regulatory centers, central public health laboratories, pharmacy units for special medicines, and care units. b) Focus on measures to contain the disease and the increase in hospitalizations, logistical support in the provision of supplies, equipment and medicines, and complementary support for highly complex transportation.
Funding	a) Acquisition of personal protective equipment, supplies and medicines, payment of daily hospital bed rates and hiring of professionals. b) Making investments, such as purchasing equipment, health transport, structuring of units, renovations, expansion of physical spaces and construction of temporary structures. c) State co-financing to encourage actions in municipalities. d) Investments following regionalization guidelines.
Cooperation	a) Coordination with the Northeast Interstate Consortium for Sustainable Development to purchase vaccines. b) Consortiums' role in providing care services.

Source: Prepared by the authors.

Results

The plans' analysis sought elements of the dimensions of the SUS state coordination, whose main actions are systematized in *table 2* by State.

We found several arrangements for state management of the fight against COVID-19 in the dimension of 'health emergency coordination'. Twenty-one plans referred to structures coordinated by state health secretariats, generally called emergency operations centers or crisis committees, exclusive to the health sector or integrating other public policy areas. Concomitantly with these spaces, five states mentioned other committees or equivalents within the state government, with participation by the governor and the state agencies involved. We should underscore that state coordination was assumed in all plans, as was the importance of structuring actions within the state and municipal management spheres.

The dimension of 'federative coordination' provided varying details on the participation of municipalities and integration with the inter-management bodies of the SUS. Fourteen plans mentioned the participation of the Council of Municipal Health Secretariats (COSEMS) – the body representing municipalities in the states – in emergency operations centers or equivalent. Another seven states mentioned participation and coordination with municipalities in a broad manner. The need to promote integrated actions between the three management spheres was highlighted in 15 contingency plans. The agreement on pandemic response measures in SUS deliberative forums (bipartite and regional inter-management committees) was mentioned in 14 plans. In particular, the role of these forums was identified with specific themes, such as regional agreement on services, guarantee of logistics and supplies, enabling of beds, allocation of resources, organization of vaccination, and gradual resumption of activities. In this sense, most plans emphasized the importance of basing decisions on technical guidelines considering the advancement of scientific knowledge about the disease.

In the 'regulation' dimension, we underscore that all the plans guided the stakeholders in regulating health services. The description

of access flows, the definition of protocols, and information on the available reference network were presented in 16 plans. Using specific tools and information systems for regulation was addressed by three states.

In the 'technical support' dimension, all states had advisory measures to municipalities, considering the adaptation needs imposed by the pandemic, specifically in health surveillance and primary care. The plans included suggested strategies for implementing actions in municipalities and disseminated guidance materials for health services. Specifically, we highlight permanent education actions aimed at municipalities, mentioned in 19 plans, and the work of the health secretariat's regional units indicated in nine plans.

The 'communication' dimension evidenced that all states developed or adapted specific pages and information panels to promote transparency. Communication measures with municipalities were found in 22 plans, such as by disseminating bulletins, reports, and technical notes. Moreover, most plans showed strategies to strengthen official communication channels. Twenty of the plans analyzed indicated partnerships with the press, eight said they monitored fake media and news, and three disclosed reliable websites.

Considering 'integrated planning', all showed action planning considering elements such as installed capacity and the epidemiological situation. In turn, the regional design stood out in the plans of 19 states. Support for municipal plans was notable, with 19 including measures to build plans and 10 stating that they monitored them. Integration and alignment of priorities between State and municipal instruments were included in seven plans.

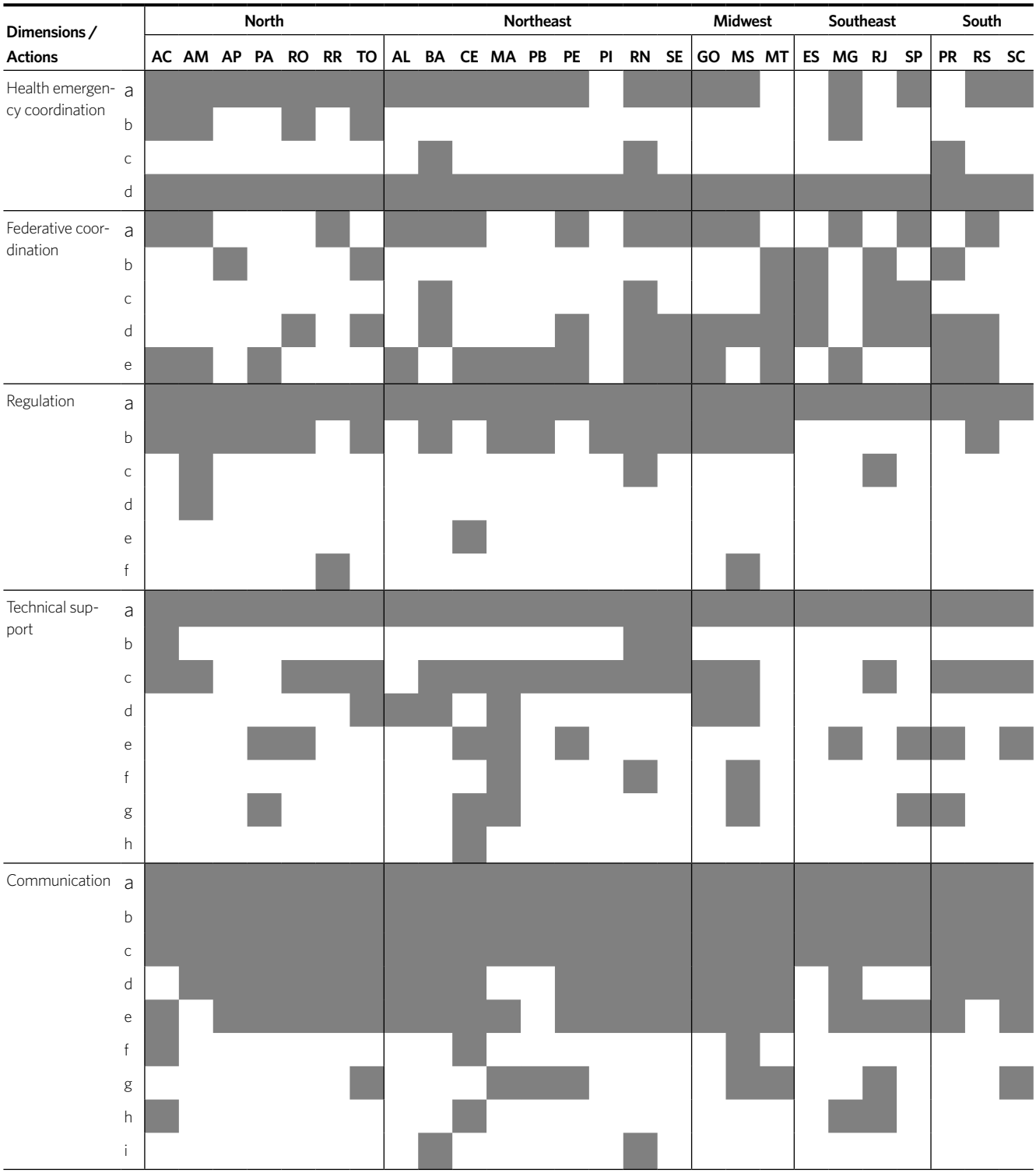
The 'service provision' dimension was found in all plans, in the most diverse areas of the healthcare network, from direct service delivery to logistical support, complementing the municipal offer and providing highly complex services. Hospital care stood out, while an emphasis was placed on health surveillance services. All states showed extensive action by healthcare units under state management, which, in many cases, were references for the care of severe cases. Activities such as monitoring bed occupancy, projecting cases, suspending elective surgeries, implementing telemedicine, opening beds, and setting up field hospitals stood out to contain the increase in hospitalizations.

In the 'funding' dimension, we identified actions in all plans, whether regarding the state entity functions or cooperation with the municipalities. The acquisition of medicines and supplies was relevant regarding cost, especially testing materials and personal protective equipment, besides procurement of beds and staff remuneration. Investments in the network were addressed by acquiring goods, such as ambulances, and permanent equipment, such as those used to expand beds.

Construction and renovations were reported, whether temporary structures, such as field hospitals and testing centers, or permanent ones, such as the expansion of central sample analysis laboratories. Notably, although two plans extensively mentioned prioritizing investments in the in-house network and following the regionalization guideline, this point was hardly addressed in the states. In the context of financial support to municipalities, four states reported co-financing, focusing on improving primary care services and supplementing the cost of beds.

Finally, only three contingency plans mentioned horizontal cooperation measures, with the State of Acre reporting coordination with the Northeast Interstate Consortium for Sustainable Development for the acquisition of vaccines when negotiations for the vaccine purchase were beginning in the country. The State of São Paulo mentioned consortiums' role in providing care services. Bahia's contingency plan did not describe how the State's consortiums would operate.

Table 2. State coordination actions to respond to COVID-19 by dimension of analysis of contingency plans



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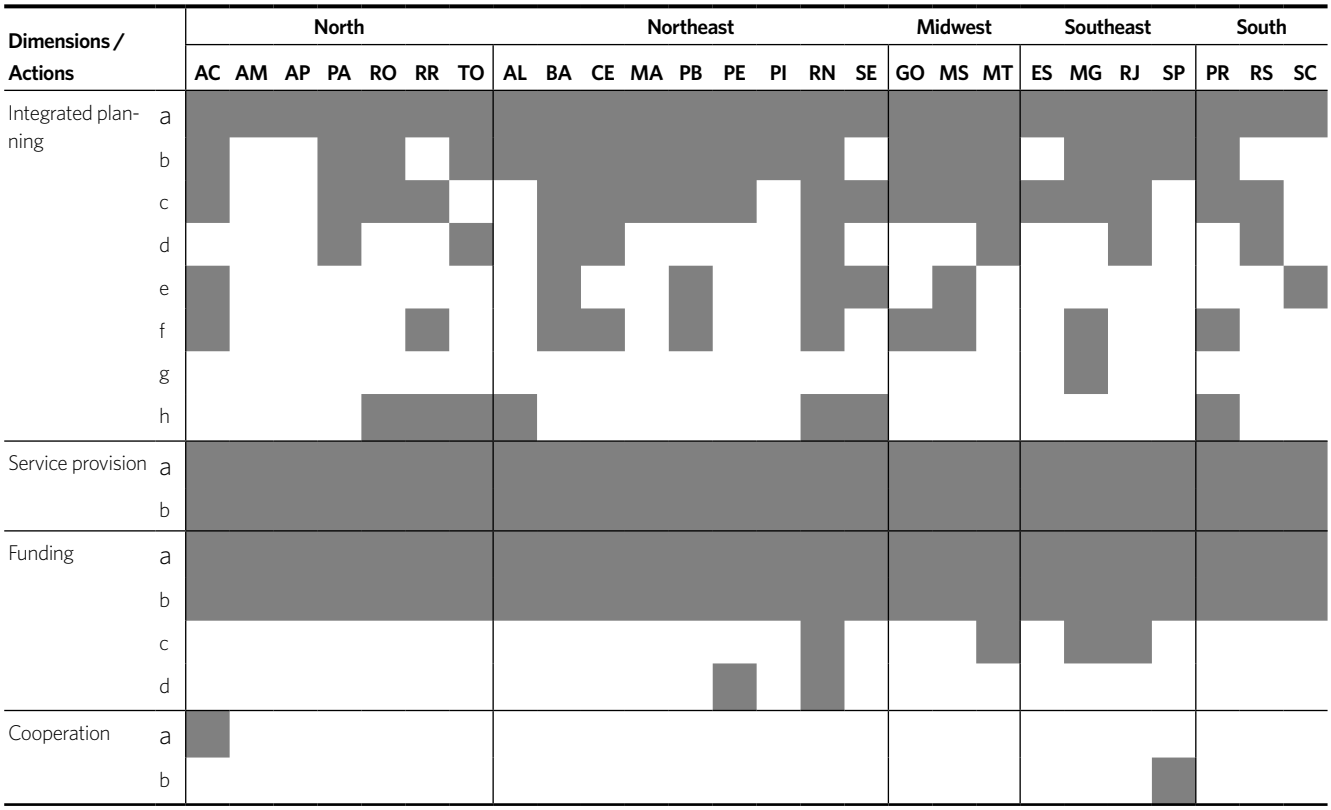

Source: Prepared by the authors. Note: The actions are identified in *table 1*.

Discussion

The analysis of the contingency plans revealed a response marked by consolidating the functions recommended for the state entity and strengthening the SUS institutional devices, even with existing interstate and regional differences.

The expanded composition of the health emergency coordination structures suggests the search for alignment, cooperation, and agility in measures involving different segments in the state response and the uniqueness of the messages transmitted to the population. However, the level of sectoral articulation or centralization of decisions has not been assessed. The recognition of the state coordination's role at all levels indicates a shift in the historical trajectory of federative coordination in the SUS, directed by the federal level, especially in national demands. Thus, it reinforces the leading role of state governments, specifically governors, in conducting actions to combat the pandemic[13,34].

According to Freeman and Maybin's[35] reflection on documentary analysis, the critical characteristic of the policy document is how it is produced and used collectively, serving as a source reflecting the public authority's stance and a vehicle communicating official commitments. In this sense, specifically regarding federative coordination, we underscore the intergovernmental collaboration in the different measures, such as the participation of municipalities in the preparation of state contingency plans or the broad action of the SUS inter-management committees.

Although it is impossible to specify the municipal participation level or the collegiate spaces' effectiveness, the plans showed the relationship between shared decision-making and relevant issues, such as the definition of vaccination strategies. These aspects reinforce the agreement bodies as fundamental spaces for formalizing cooperation actions and building consensus in promoting aligned responses. They also revealed that the plans were technical instruments to support the positions of SUS managers, such as, for example, on the use of medications for COVID-19. These findings converge with studies that found that governors acted autonomously regarding COVID-19 containment measures, even those who politically supported then-President Jair Bolsonaro, following the technical recommendations and evidence provided by the state health secretariats[15].

Regulation, historically established as a state function, suffered the impacts of the pandemic since scientific evidence in early 2020 pointed to the exhausted hospital care capacity and the need to reduce the speed of spread of the disease, reorganize supply, and expand the number of beds, especially in regions with care gaps[36]. We identified that the contingency plans provided technical information to guide the services involved but, above all, provided transparency regarding the procedures and criteria in logistics and the allocation of beds. Notably, in this context, the states were pressured to respond to the population while addressing high hospital occupancy rates, besides the historic bet shortages[36].

Regulation in the states raises aspects of the lack of national coordination, such as organizing a possible single queue, a topic that became an agenda of the federal Legislative Branch in 2020 in several bill proposals but which has made little progress[37]. Although the Ministry of Health promoted the expansion of bed qualifications and the increase in the amounts paid for daily rates through mobilization and authorization from the Legislative Branch, the unequal distribution of the supply of hospital resources in the country did not change, besides observing resistance to proposals for integration between public and private services[38,39].

Regarding technical support, we underscore the range of issues the states addressed during the health emergency and the strategies used to contain the spread of the disease and the overload of services. The results suggest that states with a developed institutional structure that was decentralized in the health regions possibly promoted actions closer to and integrated with the municipalities. Bahia's successful experience in institutional support and coordination of primary care in municipalities[40] is noteworthy. On the other hand, an analysis of state contingency plans identified superficial actions proposed for continuing education, highlighting the need to include measures to qualify SUS workers in strategic agendas[41]. We should consider that although the evidence from this study points to the provision of support to municipalities in all states, we observed variations in the description of the type and complexity of the support offered – aspects not assessed in this study.

Regarding communication, the special attention paid to strategies for disseminating official information and combating the spread of fake news aligns with an assessment of the transparency of information provided by states, which showed that there was a greater emphasis on publishing information about pandemic data and decision-making rather than financial and budgetary information[42]. On the other hand, analyzing the adequacy of the communication strategies developed by the three entities during the pandemic highlighted weaknesses and the need for greater inter-federative coordination and overcoming authoritarian communication practices[43].

The situation found in integrated planning and the broad support given to municipal contingency plans exemplify the search for alignment of actions and the recognition of the necessary collaboration with municipalities to achieve the common objective of saving lives through measures to contain the virus and

reduce case severity. On the other hand, effective integration between State and municipal instruments was rarely mentioned, suggesting the fragility of bottom-up and integrated planning. There was a reference to the report on the experience of the State of Paraná in supporting and evaluating municipal contingency plans, verifying limitations in the organization capacity in the territory, and the potential of the process of qualifying the instruments[44].

Concerning service provision, the plans included measures to promote prevention and case detection, reducing the disease's transmission speed. The literature on the actions of state governments highlighted their leading role in preventive measures and virus containment, based on state decrees[45], and highlighted that they were fundamental in Brazil's efforts to slow down the transmission rate[46]. On the other hand, the emphasis on actions to increase hospital care capacity and avoid a shortage of beds was notable in the analysis of the plans, highlighting the importance of hospital care in state services.

Regarding funding, the lack of emphasis on prioritizing expenses per the regionalization guideline is due to the lack of national guidelines that could guide investments that meet criteria per health priorities to reduce health disparities. This setting was also influenced by the fiscal difficulties endured by state governments since 2014. A study showed that the lack of coordination at the federal level during the pandemic led to unequal, insufficient, and inefficient results in federal financial support policies for states[17]. In this sense, using the co-financing instrument was insignificant in state coordination actions. Finally, albeit with less expression in the documents analyzed, consortia played a vital role in intergovernmental relationships and horizontal cooperation[16].

Final considerations

This study showed how state coordination of the SUS was structured in response to the pandemic based on COVID-19 contingency plans. The results suggest the leading role of state governments in managing the SUS. Albeit with variations, the states assumed the role of coordination, seeking integration, alignment, and cooperation between the sectors involved. Attention was paid to the need for communication and transparency of actions, besides decision-making based on scientific guidelines and evidence. We underscore the role of the SUS inter-management committees as spaces that legitimized the measures undertaken and fostered intergovernmental collaboration. On the other hand, the federal absence in national coordination, explored in the literature, reflected on the functions of the state entity and in the identified situations. The states employed plans to direct actions and cooperation around common objectives in a macropolitical context of polarization, federative dispute, and national lack of coordination.

Although most of the dimensions have been covered in the plans, studies that analyze the stage of their development in the states are needed. In this sense, it is worth noting that different macrostructural conditions affect the states, evidencing asymmetrical states socially and economically and at different stages of development of institutional capacities, aspects that certainly reflect in the experiences analyzed.

The results of this study corroborate the understanding that a set of actions accessible in the state coordination plan needs to be explored. Thus, other studies are required to elucidate, for example, what types of coordination were formed and how the actions foreseen in the plans were implemented.

Finally, it should be noted that this study was limited to information from the editions of the selected plans, understanding that these documents have undergone updates over time. Therefore, the measures defined by each State could not be compared linearly over time. In a situation that combined the complexity and urgency of the pandemic with adverse political and institutional conditions, the experience

of state coordination showed the importance of strengthening federative autonomy, the cooperative nature, and institutional capacities in the SUS.

Acknowledgments

The article is one of the products of Ferreira ACC's doctoral thesis, developed within the ENSP/FIOCRUZ Postgraduate Program in Public Health. Lima LD is a research productivity fellow of the National Council for Scientific and Technological Development (CNPq) and a Scientist of Our State of FAPERJ and relies on the support of these agencies to develop studies on the subject.

Collaborators

Ferreira ACC (0000-0003-2524-5234)* e Lima LD (0000-0002-0640-8387)* contributed to the manuscript's preparation. ■

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Received on 08/01/2024
Approved on 23/05/2024
Conflict of interests: non-existent
Financial support: The Program for the Promotion of Scientific and Technological Development Applied to Public Health of ENSP/FIOCRUZ supported the publication. The following grants supported the research: National Council for Scientific and Technological Development – CNPq, File N° 309295/2021-1; FAPERJ – Carlos Chagas Filho Foundation for Research Support of the State of Rio de Janeiro, File SEI E-26/201.123/2021; FAPERJ – Carlos Chagas Filho Foundation for Research Support of the State of Rio de Janeiro, File Nº E-26/010.002257/2019, Notice Nº 14/2019 – Support for Emerging Research Groups in the State of Rio de Janeiro.

Editor in charge: Jamilli Silva Santos