Work process in the Family Health Strategy oriented to people with overweight and obesity in São Paulo

O processo de trabalho na Estratégia Saúde da Família voltado às pessoas com sobrepeso e obesidade em São Paulo

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ABSTRACT The goal of the article is to analyze the characteristics of the work processes in the Family Health Strategy directed to people with overweight and obesity in the city of São Paulo. Based on the theoretical framework of collective health about work processes, an exploratory study with a qualitative approach was developed. Eleven interviews were conducted with professionals from a basic health unit, in the east of the city of São Paulo, between July and August 2019. Starting with the thematic analysis, the article presents the results and discussion in three analytical categories: work object, work instruments and work organization. The care for people with overweight and obesity is mediated by the low investment in training health professionals on the subject, the lack of technical materials to support the work and the management model based on productivity and demand for quantitative results. It is concluded that health professionals have little control over their work process, whose purpose ends up being the change of behavior and the loss of body weight, instead of considering the health needs of users and professionals, sometimes producing dissatisfaction and weariness with work.

KEYWORDS Obesity management. Primary Health Care. Quality of health care. Working conditions. Unified Health System.

RESUMO *O objetivo do artigo é analisar as características dos processos de trabalho na Estratégia Saúde da Família direcionados às pessoas com sobrepeso e obesidade no município de São Paulo. Ancorado no referencial teórico da saúde coletiva sobre processo de trabalho, foi desenvolvido um estudo exploratório com abordagem qualitativa. Foram realizadas onze entrevistas com profissionais de uma unidade básica de saúde, na zona leste da cidade de São Paulo, entre os meses de julho e agosto de 2019. A partir da análise temática, o artigo apresenta os resultados e a discussão em três categorias analíticas: objeto de trabalho, instrumentos de trabalho e organização do trabalho. O cuidado às pessoas com sobrepeso e obesidade é mediado pelo baixo investimento em qualificação dos profissionais de saúde sobre o tema, pela falta de materiais técnicos de suporte ao trabalho e pelo modelo de gestão pautado pela produtividade e cobrança de resultados quantitativos. Conclui-se que os profissionais de saúde apresentam pouco domínio sobre seu processo de trabalho, cuja finalidade acaba sendo a mudança de comportamento e a perda de peso corporal, em vez de considerar as necessidades de saúde dos usuários e profissionais, produzindo, por vezes, insatisfação e desgaste com o trabalho.*

PALAVRAS-CHAVE *Manejo da obesidade. Atenção Primária à Saúde. Qualidade da assistência à saúde. Condições de trabalho. Sistema Único de Saúde.*

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Introduction

As a space for users' first contact with the Unified Health System (SUS) in the country, the organization of Primary Health Care (PHC) has the Family Health Strategy (FHS)[1] as its priority model of assistance. Several authors emphasize that the expansion of the ESF in the last 30 years represents the growth of primary care for the population, the increase in the supply of services in peripheral and rural regions and the reduction in hospitalizations for causes sensitive to PHC[1-3]. They also highlight that the FHS assistance model seeks to oppose the biomedical model and promote multidisciplinary work based on bonding, reception, community guidance and SUS principles[1,3-5].

Despite this, there are several challenges for the realization of the FHS in the SUS, with the flexibility of political prioritization to strengthen this care model, overload of health professionals, lack of training for work, insufficient funding and cuts in resources for the SUS[3,4,6-11]. Added to this are population aging and worsening working conditions, with an increase in unemployment and informal employment rates[12], which impact the population's health and nutrition parameters.

The loss of the quality of what is consumed, with the increase in the intake of ultra-processed foods (with high caloric value and low nutritional value), at the expense of fresh foods or homemade preparations, has been related to the increase in diabetes, systemic high blood pressure and food and nutritional insecurity, both in the profile of nutritional deficiencies as well as overweight and obesity in the population[13,14]. The World Health Organization (WHO) considers obesity an epidemic and a global public health problem, which is why it has been a priority of public policies in recent decades, mainly due to its relationship with the development of other chronic diseases, such as cardiovascular ones. In Brazil, in regard to overweight and obesity (BMI greater than or equal to 25kg/m^2), it is noteworthy that, in 2019, the prevalence of overweight and obese adults reached 61.7% and 26.8%, respectively[15].

Although there is a consensus in the literature about linking the growing prevalence of overweight and obesity to different dimensions (political, economic, social, cultural), the understanding of the relationship between these multiple factors and the elaboration of intervention proposals is still complex[16]. Nationally, the Ministry of Health has elaborated documents that guide care practices, such as 'Primary Care Booklet nº 38 – Obesity'[17]; and the Clinical Protocol and Therapeutic Guidelines (PCDT) for Overweight and Obesity in Adults[18]. In the city of São Paulo, the Service Protocol for the Overweight and Obesity Care Line seeks to support health professionals and qualify nutritional care in the Health Care Network (RAS)[19].

Given the challenges presented, this article seeks to highlight the working conditions offered to health professionals in the FHS for the care of overweight and obese people in a large city like São Paulo, in order to provide subsidies for the qualification of work processes in the SUS in similar realities. Thus, the aim of the article is to analyze the characteristics of the work processes in the FHS aimed at overweight and obese people in the city of São Paulo.

Methodology

A case study with a qualitative approach was carried out in a Basic Health Unit (UBS) located in the east of the city of São Paulo. This UBS was selected because it had the ESF as a way of organizing the work process, it had an Expanded Family Health Center (Nasf) team and its participation in the study was approved by the Municipal Health Department.

The UBS studied had five family health teams (eSF), and, during the research

period, two teams were incomplete with the absence of a medical professional. In addition, the UBS had three oral health teams, an environmental promotion agent (APA) and a team from the Nasf, consisting of a nutritionist, a psychologist, a social worker, a speech therapist, an occupational therapist, a physiotherapist and a gynecologist. Since 2016, the management of the UBS and the hiring of professionals has been indirect, that is, through a public-private partnership, with the municipality's contracting with a Social Healthcare Organization (OSS).

Between July and August 2019, data collection was carried out, initially, with a period of approximation of the researcher to the field, through participant observation and, later, with semi-structured interviews with professionals. Professionals with higher education (eSF doctors and nurses) and professionals who coordinated educational groups with users focused on issues related to nutrition and weight loss in the unit (Nasf and APA professionals) were selected. The interview script was structured in five dimensions, namely: interviewees' profile, work routine, conception about overweight and obesity, professional training and work process for overweight and obese people.

Based on the concept of work process in health[21], analytical categories were previously defined to guide data analysis. The categories represent the components of the work process and will be presented in: (1) Object of work: object or subject that receives intervention from the care practices offered; (2) Work instruments: includes the care practices carried out in the health service, the knowledge of health professionals about overweight and obesity and the technical support materials used; and (3) Work organization: management model, care model in the FHS and the purpose of the work performed.

In order to preserve the identity of the interviewees, the extracts from the interviews were coded as E (1 to 5) for nurses, M (1 to 3) for physicians, N (1 to 3) for Nasf and APA professionals. The study was approved by the Research Ethics Committee of the Faculty of Public Health of the University of São Paulo and by the Research Ethics Committee of the Municipal Health Department of São Paulo. All participants signed an informed consent form.

Results

Eleven interviews were carried out with professionals from the UBS, most of them women (81.8%), nurses (45.4%), hired under the Consolidation of Labor Laws (CLT) (90.9%) and with time at UBS ranging from 3 months to 15 years. The profile of the participants is detailed in *table 1*.

Table 1. Profile of professionals interviewed according to code, gender, age, time since graduation, specialization, time at the UBS, previous trajectory and type of contract. São Paulo, 2019

Code	Sex	Age	Time since graduation*	Especialization/postgrduation in public health or collective health or family health	Time at UBS*	Previous trajectory in public health	Type of contract
E1	F	47 years	16 years	Yes	15 Years	Yes	CLT
E2	F	38 years	8 years	Yes	7 months	Yes	CLT
E3	F	50 years	18 years	Yes	8 Years	Yes	CLT
E4	F	43 years	16 years	Yes	11 months	Yes	CLT
E5	F	49 years	16 years	Yes	15 Years	Yes	CLT
M1	F	40 years	9 years	Yes	3 months	Yes	Mais Médicos Program
M2	M	28 years	1.5 years	No	1 year and 2 months	No	CLT
M3	M	29 years	1 year	No	6 meses	No	CLT
N1	F	31 years	10 years	No	4 Years	No	CLT
N2	F	32 years	8 years	Yes	3 Years	No	CLT
N3	F	28 years	7 years	No	4 Years	Yes	CLT

Source: Self elaborated.

*Until august 2019.

Object and work instruments

During two months following the work routine at the UBS, it was noted that this did not differ much from the routine recommended for the eSF nationwide. The professionals' routine, organized by an agenda made by the local management, preserved the logic of organization aimed at meeting the lines of care, especially with the production of consultations and groups. Although the organization of the FHC is based on care lines, professionals reported not knowing the city's overweight and obesity care lines.

The main activities carried out were individual consultations, team meetings, home visits and groups. Consultations with a doctor or nurse, as well as with Nasf professionals, were considered by the interviewees as a space for caring for overweight and obese people. In addition, the groups were identified as an important way of caring for overweight and obese users, especially the group entitled 'On Measure', organized by the nutritionist.

In the UBS observed, even though the care shared between eSF and Nasf was mostly done in a fragmented way – cases of pain for the physiotherapist, overweight and obesity for the nutritionist, psychological distress for the psychologist –, the Nasf team was recognized by the professionals of the eSF as a support. Respondents considered that Nasf professionals, with specific knowledge, gave support in handling cases in which eSF professionals had more difficulty working, thus expanding their care capacity and qualifying the health care provided. The flow of care for overweight and obese people who arrived at the service, especially in cases of higher BMI and comorbidity, went mostly through the care of a professional from the Nasf team, demonstrating the importance of this team in caring for people overweight and obese.

Despite the typical working week being composed of several activities that included overweight and obese users, this was not necessarily linked to the quality of what is offered. In general, professionals recognized the lack of informational material provided by the UBS

and that they often used their own resources to prepare materials. *"There is no folder here, but I know there is one of the notebooks that has the issue of obesity and there is a nutritionist that we can always report to"* (E1).

Only the Nasf nutritionist pointed out that she used the Food Guide for the Brazilian Population as support material.

A doctor presented another point as a weakness for the care of overweight and obese people: the absence of a protocol. In her report, she pointed out that this discourages prioritization of care, as if only the cases that had established protocols were the cases that should be followed up:

> *I don't have a time or an environment where I can place the obese, a protocol has not yet been established. As there is no protocol that supports you, you will not comply much with that.* (M1).

When we asked the professionals to tell us about a case of overweight and obesity that they followed – the first case that came to their minds –, complex cases and grade III obesity that involved psychological distress, childhood obesity cases and cases of ' success' in which serviced users lost weight were highlighted. The measurement of a good job seemed to be more validated by the professionals themselves when it culminated in weight loss, being a source of professional satisfaction and success in the work performed.

Nurse E1's speech showed that job satisfaction is closely linked to change in user behavior:

> *I feel bummed that he doesn't do it, but I shouldn't be, because it's his answer to himself. There are very few cases that the person does not understand, but, in the vast majority of cases, the person knows that it is not doing them any good, but they look at you, in your eyes, and say: 'but at this moment it is what makes me happy'. The professional can reach such a place, but the important thing is that you will also be like that, that the person understands that it is not doing them well, but at that moment they do not have anything else that will do as well for them as eating, as not leaving the house, and we try to make them do it differently.* (E1).

When asked about ways to improve the care of overweight and obese people in PHC, the interviewed professionals made some suggestions. Among the suggestions related to the work process, the following stood out: the need for more training spaces for health professionals on overweight and obesity; hiring more health professionals, especially Nasf professionals, such as a nutritionist and physical educator; more investment in health promotion instruments, such as vegetable gardens and the strengthening of a secondary care network dedicated to the care and monitoring of overweight and obesity cases.

In addition to the suggestions related to the work process at the PHC, the professionals presented suggestions that involved the education, employment and income sector and urban planning. The suggestions presented demonstrate that professionals understand overweight and obesity as a result of multiple factors, and that more comprehensive care for overweight and obese people in the country needs to undergo improvements in the health sector and beyond. Despite this understanding, none of the professionals mentioned the social participation of users and professionals themselves as political agents of transformation.

Work organization

Under the argument of better efficiency, the municipality of São Paulo defined managerialism as a management model and as a way to expand the city's PHC in 2001[22]. The municipality is responsible for regulating the implementation of public health policy based on the preparation of management contracts. In the city of São Paulo, due to the enormous territorial extension, the public-private partnership varies according to the administrative division and its regional coordinators.

The production report is available every six months on the website of the OSS hired for the management of the UBS studied. In the spreadsheet provided by the OSS, it can be seen that the monthly goals are directed to the eSF and have indicators for the number of FHS doctor consultations, FHS nursing consultations, home visits by community health workers, individual consultations, procedures of the oral health team and obtained by each UBS in the healthcare network.

Although the production report only contains these indicators, professionals are also subject to other forms of work monitoring, such as delivery of a follow-up list of lines of care for local management, established vaccination goals and other procedures; and, for NASF professionals, monthly targets for groups and visits.

The collection of production goals appeared in the interviewees' statements as a difficulty encountered in the work routine for the care of overweight and obese people, especially due to its effect on the length of service.

> *Unfortunately, our time at SUS, at UBS, is 15 minutes. There is no time to work on this, the most that you can do is to diagnose obesity, high BMI, but then we are able to work in other areas, referring to nutrition, a psychologist.* (M2).

In addition, for professionals, work at the UBS is hampered by the high turnover of doctors and the high demand for work.

> *When there is a doctor, you can share. When there's no doctor, the schedule doubles, fills up faster, because everyone wants to see a nurse, but I don't have the autonomy to do the exam, so I have to make an appointment with another doctor, from another team, so it ends up demanding a large number (of appointments), because there was already a lack of doctors, and now I almost don't get a place for my team to be able to schedule.* (E5).

The established production goals guide, to a large extent, the activities developed in the work routine, as they define the professionals' agenda. The time allocated for appointments is a consequence of the number of appointments expected for doctors and nurses, which implies, respectively, 15 minutes and 20 minutes for appointments. When asked about the difficulties in monitoring overweight and obese users in the service, medical professionals, in particular, complained about the time allocated to consultations.

With the time allocated to consultations, the health work process is directed towards solving the complaints presented by the service users. Physician M3 pointed out that the goals imposed on his work changed his medical practice, and it was necessary to make adaptations and prioritize actions, thus justifying the logic of the complaint-conduct applied in the consultations. The professional mentioned in his speech the idea of the impossibility of changing the service time, demonstrating a feeling of impotence in decision making. When talking about the actions developed with overweight and obese people, the doctor spoke about the consultations:

> *The contact we have is during the consultation. And during the consultation, we say: 'You are obese and you have to do this and that', but there is no way for us to elaborate much on this. At first, when I was still detached from the goal, I would do a little better orientation: 'What time do you wake up? What time are you going to sleep? What do you eat in the morning? What do you have lunch? What time do you have dinner? Have something mid-morning mid-afternoon? What is it?' I used to make a small menu, designing a prescription for the patient to see, dividing the plate in half, dividing half of the half [...] but it turns out that in the 15-minute consultation, it's not possible. I saw that these patients I attended at the beginning, many of them managed to have a result of weight loss, pressure reduction, diabetes control, and they report that it was very good that they teach others to do the same thing.* (M3).

It goes on to explain why clinical practice has changed:

> *So, because in the first few months, they* [management] *have a tolerance because you're starting. [...] In the first month, I didn't even have a defined schedule, the schedule was a bit abstract, so I had more flexibility, and even so, it was: 'Ah, but you didn't hit the target, but you are starting, so it is ok'. When tolerance ended, then things got more complicated. Then we start cutting things. So, this was something I did with all overweight and obese patients, I did this orientation, but I had to cut it off. For example, I performed the more complete physical examination, cardiac auscultation, assessed the abdomen, felt, then I cutted it. Now, I only direct them to complaints, for example, the patient that has no high blood pressure, is not diabetic, came complaining of pain in the shoulder, I only do a shoulder exam. It's something very focused, very much like in the emergency room.* (M3).

Complaints about consultation time were more present among physicians than among nurses. On the other hand, medical turnover appeared more among nurses, as a difficulty in organizing the work process, carrying out longitudinal care and as a factor for overloading these professionals. In some statements, it was also possible to identify the idea of vocation, help and donation to work as elements of professional satisfaction and motivation for work.

Discussion

Body weight as the center of care and (dis)satisfaction of workers with work results

The hegemony of the concept of obesity as a health risk in the policies that guide work in the SUS[16] places the health professional in the role of standardizing bodies through interventions to prevent health risks, with a focus on weight loss. The name given to the group on nutrition at the UBS studied ('On Measure') exemplifies the focus of care practices, placing body weight as the main object of intervention and access criterion. Thus, the health work process is guided by the definition of the object – body weight – and often only makes sense for professionals when there is a resolution of the problem presented, that is, when users follow the recommendations and prescriptions performed by the professional or when the treatment outcome approaches the healthiest and lowest risk pattern.

However, the roots of the development of overweight and obesity, which are socially determined, are not taken as the object of the activities carried out, which purpose is to change eating habits, physical activity and weight loss. Such practices have the potential to meet only a part of the users' health needs, a factor that may justify the difficulty encountered by professionals in adhering to the proposed therapeutic process. Difficulty in adhering to obesity treatment can lead to frustration in health professionals linked to the feeling of impotence and unpreparedness to deal with these cases, and to blame users[23].

Another aspect that influences job satisfaction is related to patterns of weariness[24] of workers. This pattern is linked to the type of work process established, the process of valuing that work, and the workloads. Workloads, in turn, are understood as demands on the organization of work and on the worker, both with internal materiality (control, psychic tension, etc.) and external materiality (physical, biological, etc.). The correlation between these loads generates in the worker's body a need for adaptation and, possibly, a compromise of the biopsychic abilities, effective or potential for work development, which can lead to wear and illness[24].

Therefore, elements linked to the organization of work – lack of employees, overattribution and high workload – and to work management – evaluation by productivity and excessive control over work – can generate an

increase in the workload of professionals at the studied UBS. Biff et al.[25] identified in the work of FHS nurses elements linked to increased workload, such as lack of infrastructure, shortage of professionals and excess of assignments; and the reduction of the workload, such as the proper functioning of care networks, the resoluteness of actions and work instruments in adequate quantity and quality[25]. All these loads influence the way professionals work, their satisfaction and, consequently, the care offered to overweight and obese people.

Regarding the training of health professionals and access to work support materials, the insufficient investment in permanent training and the distance between the technical materials that have already been produced by the management and their use in the service's practice point to weaknesses in the production of qualified care. Lopes et al.[26] cite the lack of professional qualification on obesity and the absence of support materials for the practice of health professionals as barriers to care for people with obesity in the SUS.

In this sense, permanent education is pointed out by authors as a need for Brazilian PHC, as it can enable collective reflection on work processes and facilitate the implementation of specific protocols for comprehensive care for people with obesity[27] and improve the quality of management and health care[28], through the production of new intentions and meanings of care among professionals[29] and inducing changes in care practices[30].

Management model and the organization of care

We saw that the productivity model impregnated in the municipality's FHS influences the work process and, consequently, the professionals' care practice. Even though there is no need to address the food issue in every consultation, the impossibility of this practice, determined by the limited consultation time, even with the need detected by the health professional, leads to the secondaryization of actions related to health promotion and to food and nutrition. In this sense, Machado et al.[31] point out that the lack of management induction for food and nutrition actions by health teams may be one of the reasons for the low performance of these actions in PHC, adding to the inadequate physical structure and lack of permanent education for the incorporation of care tools.

It is noted that the care model and the activities offered to users in their work process are influenced by the management model adopted. In the logic of productivity and with little time for care, the most acute health issues tend to be looked at and treated more, in contrast to health promotion and disease prevention activities. In addition, it is noted that health professionals tend to associate the care of people with overweight and obesity as an almost exclusive attribution of the nutritionist or physical education professional, which can generate a lack of co-responsibility for the care of the referred users[32]. The search for productivity also influences the way professionals interact, creating tensions between a more collaborative interprofessional practice and a more traditional practice, centered on procedures[32].

In the health sector, managerialism is expressed in the outsourcing of health policy execution and health work management to private non-profit institutions, such as Non-Governmental Organizations, Social Organizations, State Foundations, among others. The municipality is responsible for regulating the implementation of public health policy from the contracting and elaboration of management contracts. This allows for the flexibility of work relations and forms of hiring, remuneration, qualification and autonomy of professionals[22,33,34].

The management contract established between the Municipal Health Department of São Paulo and the contracted institution discusses parameters for payment and performance evaluation per service line, indicators used for the evaluation, production targets for

eSF and other agreements and obligations established between contracted and contracted. Based on the result management mechanism, the total financial transfer to the contracted OSS is subject to compliance with at least 85% of the parameters established in the management contract, and values below 85% suffer progressively from the loss of budget.

It is noteworthy that the evaluation and monitoring of work are fundamental for the (re)organization of the work process, as elements for individual and collective self-reflection, as a way to consolidate social rights and society's participation in public decisions. However, submitted to the logic of capitalist productivity and without the participation of workers and users in its elaboration and execution, they distance themselves from its social intention and serve as a means of controlling expenses and controlling health professionals[33,35].

The performance evaluation adopted in health is a management tool that generates over-intensification of work in the search for 'optimization' of financial resources and greater extraction of added value in the sector. As costs in the health sector are mostly linked to the hiring of the workforce, especially in PHC, cost containment and the search for greater work efficiency fall on health workers and their performance. In other words, the evaluation of work in health, under the managerial paradigm, is reduced to the control of the production of quantifiable activities, services and procedures in health and the individual responsibility of professionals[33-35].

Souza[36] opposes the idea that health work is a privileged space for political disputes and changes in the capitalist production process, as the subjects involved in the act of care, professional and user, are subjected to dehumanizing and alienated conditions in their work process. Health work does not follow its own logic, but reproduces the general logic of work, even if the product of this work is immaterial, through health care. Thus, contradictorily, the greater the dedication of health professionals to meet the needs of users, the greater the chance of illness, absenteeism and weariness when dealing with users. In other words, dehumanized care is primarily the result of capitalist production relations, strongly marked by the exploitation and alienation of work.

Even so, the interviewed professionals strongly carry in their discourse the idea of health work as a work of helping others, of helping the most 'vulnerable', demonstrating a disconnection between health work and the category of work and a distancing from the notion of access to health services as a right of the population.

The precariousness of working conditions, work overload, high number of consultations, structural problems, little appreciation within the medical category, little autonomy for action, low resolution of actions and a deficient support network at other levels of health care are some of the factors[37] that justify the medical turnover experienced in the studied UBS. The constant change of doctors also leads to a break in teamwork, requiring a constant renegotiation and reorganization of the work process[37].

Final considerations

We saw that health professionals have little autonomy and little time to define their work process, which ends up causing a precarious mastery of the work object and its purpose. For this reason, they end up being reproducers of predetermined practices and often end up frustrated with their work. In the case of activities aimed at overweight and obese people, the object of work is centrally body weight, and the purpose ends up turning to weight loss and changing risk behavior, even if professionals understand that the determination of excess weight weight and obesity have roots in social organization.

As work tools, professionals develop actions for the treatment, promotion and prevention of overweight and obesity, especially through

consultations and groups, despite showing insufficient training on the subject. On the other hand, the power of this work is conditioned to the logic of work organization in the FHS in the municipality, with the managerial model of management guided by productivity and 'optimization' of resources. With a history of flexibilization in the way professionals are hired, based on the search for better use of financial resources, this organization leads health workers to a fragmented, protocol-based care practice predominantly focused on meeting established production goals.

In this scenario, the findings of this research contribute to filling a gap in studies on the health work process aimed at overweight and obese people in a metropolis like São Paulo. Furthermore, they demonstrate that, in order to improve the care of overweight and obese people in the SUS, the training of health professionals is not enough, it is essential to improve work processes. Structural changes are needed, with more financial investment to hire professionals, guarantee of physical structure and adequate support materials for the work, a participatory management model centered on the health needs of the population, with spaces for workers' participation in decision making for their own work process. In addition, more time devoted to continuing education in the daily work of the service, in order to include and allow for greater depth in themes such as health promotion, promotion of adequate and healthy food, structural aspects related to the food environment, humanization of health care, considering the assistance to users and the work processes of health professionals.

Finally, as it is a case study with a specific focus, the article has limitations with regard to the universalization of the findings. Thus, there is a need for more studies on work processes in PHC and their structural determinants and on the impacts of such an organization on the provision of comprehensive care to the population.

Collaborators

Jesus JGL (0000-0003-0166-5568)* and Bógus CM (0000-0003-0925-2741)* contributed to the preparation of the text, analysis and interpretation of data, critical review of the content and approval of the final version of the manuscript. Campos CMS (0000-0002-1149-9025)*, Scagliusi FB (0000-0001-7861-8597)* and Burlandy L (0000-0003-0875-6374)* contributed to the critical review of the content and approval of the final version of the manuscript. ■

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