Work leave and therapeutic pathways of workers affected by RSI/WRMSD

Afastamento do trabalho e os percursos terapêuticos de trabalhadores acometidos por LER/Dort

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ABSTRACT The aim of this study was to investigate the therapeutic pathways of workers in work leave situation due to Repetitive Strain Injuries/Work-Related Musculoskeletal Disorders (RSI/WRMSD) assisted at a health service. Analysis of clinical records occurred and selection of subjects for recorded semi-structured interviews, which were recorded for thematic content analysis. Ten workers participated in the interviews, of both genders and different professions. The subjects underwent clinical conducts based on the biomedical model, due to the helplessness of the company and the National Social Security Institute (INSS), causing suffering. It was concluded that there is still a need for improvements in intersectoral and interdisciplinary actions in cases of chronic diseases and in the integral health model.

KEYWORDS Cumulative trauma disorders. Occupational health. Sick leave. Rehabilitation.

RESUMO *O estudou objetivou investigar os percursos terapêuticos de trabalhadores em situação de afastamento do trabalho por Lesões por Esforços Repetitivos/Distúrbios Osteomusculares Relacionados ao Trabalho (LER/Dort) atendidos em um serviço de saúde. Ocorreu análise de prontuários clínicos e seleção de sujeitos para entrevistas semiestruturadas, que foram gravadas para análise de conteúdo temática. Participaram das entrevistas dez trabalhadores, de ambos os gêneros e diferentes profissões. Os sujeitos passaram por condutas clínicas embasadas no modelo biomédico, pelo desamparo da empresa e do Instituto Nacional do Seguro Social (INSS), gerando sofrimento. Concluiu-se que ainda há necessidade de melhorias nas ações intersetoriais e interdisciplinares em casos de doenças crônicas e no modelo integral de saúde.*

PALAVRAS-CHAVE *Transtornos traumáticos cumulativos. Saúde do trabalhador. Licença médica. Reabilitação.*

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Introduction

A contemporary crisis manifests itself in all countries of the world in health care systems, with the increase of chronic health conditions[1]. For Mendes[1], the brazilian context undergoes an accelerated transition in the political, social, economic, demographic and epidemiological fields, such as the growth of diseases of non-infectious/transmissible origin and uncertain etiology, resulting, among other factors, from productive restructuring and accelerated aging of the population. Regarding productive restructuring, the weakening of the collectivity among workers in the new labor relations – such as, for example, outsourcing, coupled with poor working conditions – has a negative impact on the health of workers. Furthermore, there is, also, the scenario of ascension of the neoliberal ideology, where the market appears as regulator of society[2].

These changes and new ways of organizing work have had a negative impact on the health of workers, leading to various forms of illness. Of chronic character, Repetitive Strain Injuries/Work-Related Musculoskeletal Disorders (RSI/WRMSD), often, involve successive withdrawal from work for short and/or long periods, as well as limitations in daily activities[3]. The RSI/WRMSD are characterized by lesions of muscles, tendons, fascia, nerves, among others, with symptoms of pain, paresthesia, sensation of weight, etc. It is insidious in appearance, and its etiology is multifactorial and complex, involving biomechanical, cognitive, sensorial, affective and psychosocial aspects and factors related to work conditions and organization[4]. Musculoskeletal and connective tissue diseases were the second largest cause of granting of sickness benefits due to occupational accidents at social security[5]. These musculoskeletal disorders constitute a public health problem in the world due to the reduction of the quality of life and the capacity to work[3].

RSI/WRMSD develop into, often, chronic cases[6]. And the brazilian health system is focused on acute illness, not on chronic diseases, therefore, chronic conditions cannot be answered with efficiency, effectiveness and quality. Fragmented systems of health care are those that are reactive and have episodic responses, which are organized through a set of isolated health points with little communication. As a consequence, they are unable to give continuous attention to the population[1].

Regarding the treatment approach of RSI/WRMSD cases, it is strongly influenced by the biomedical model[7]. The biomedical model results in fragmented health care practices, since it dichotomizes the disease in objective and subjective aspects, focusing on the objective aspects, that is, on observable lesions, measurable symptoms and causes classifiable, having the disease center of attention, not the individual[8]. The biomedical model stimulates physicians to adhere to a cartesian behavior in the separation between the observer and the observed, many times, by the impossibility of offering conclusive or satisfactory answers to many problems, especially to psychological or subjective components that accompany them, to a greater degree or lower than diseases[9]. Still for this author, in favor of the reorientation of the economic model based on neoliberalism, the medical-assistance model, serving the biomedical model, tends to seek the interests of the market.

With the Brazilian Constitution and the implementation of the Unified Health System (SUS), the health care model was reorganized based on a comprehensive health concept, that is, taking into account the biopsychosocial aspects of health-disease processes. On the other hand, what is still seen in practice are therapeutic offers guided by the biomedical model[10]. Even if many medical professionals even admit the presence of subjective or affective components, that influence disease cases, they

do not feel comfortable, as a general rule, dealing with them[9].

Consequently, the strictly pathophysiological view in RSI/WRMSD cases is not decisive and entails extensive treatment periods, overloading public health services and negatively impacting the emotional and socioeconomic environments of workers[11]. In addition, this attention model focused on disease, generally, individualizes illness, which, in fact, is a structural and collective problem. In order to reflect on the theme, it is worth highlighting some historical facts. Worker-centered health care was, until the mid-1980s, the sole responsibility of the employer and under the model of occupational health and occupational health, which focuses on the individual view of illness, diagnosis and treatment, from the positivist point of view[12]. The epistemological limits of this model make it impossible to consider the aspects related to the organization/division of labor in the processes of illness, such as: rhythm, shift work, modes of division of labor, among others[13].

From the context of social re-democratization, the reorganization of health and the influence of the Sanitary Reform in Italy, in the 1970s, a new sanitary vision began to formulate conceptions about labor relations, health and illness, considering, as well, social determination in this process[12]. But it was in 1988 that the State, through the SUS, came to have legal competence on the work-related health-disease process, with the Federal Constitution, in article 200 – Actions related to the health of workers – endorsed by SUS regulations, with Law nº 8.080, of 1990[14]. These authors explain that, subsequently, the National Network of Integral Attention in Worker's Health (Renast), created in 2002, and the Workers Health National Policy (PNSTT), of 2012, were strategies created to guarantee integrality in the attention to the health of the worker in the Network of Attention to Health (RAS), with the Primary Health Care being the ordering of the actions. Although there are advances and strategies, there is still a difficulty for health professionals to consider work as part of the health and illness process of the subjects, and, faced with this problem, the process of care and rehabilitation of workers affected by RSI/WRMSD becomes a challenge.

There is still, in general, a difficulty in establishing the causal link between disease and work in the case of RSI/WRMSD, and, with this, the official registration of the disease is not always obtained[15]. When an accident or illness is recognized as a result of work, the company must issue the Work Accident Notice (CAT) to the National Social Security Institute (INSS). When this does not happen, the injured himself, his or her dependents, the union, the attending physician, or any public authority may carry it out at any time. This document aims to guarantee access to the accidental sickness benefit, which guarantees the worker 12 months of stability in the company when returning to work, among others[16]. In addition, its record is an important source of epidemiological information. It is worth noting that the CATs refer only to workers covered by the Work Accident Insurance (SAT). Therefore, self-employed workers, domestic workers, statutory civil servants, underemployed persons, many rural workers, among others, are excluded. Underreporting of data prevents statistical numbers related to work-related accidents from occurring in reality[15].

Once workers are separated from work because of illness, workers experience a process of major disruptions in their way of living and working[17]. Therefore, the process of removal from work deconstructs the identity of the individual, since it impedes the recognition of his social role and by assigning him a role of patient. And it is worth emphasizing how much contemporary capitalism values the productive worker, often generating socially exclusive processes in cases of illness related to work.

The objective of this study was to

investigate the therapeutic pathways of workers in situations of work withdrawal and affected by RSI/WRMSD treated at a health service.

Methods

The study is exploratory, descriptive, retrospective and with emphasis on qualitative results. The study had two stages and was carried out at the Reference Center on Worker's Health (CRST) of the Eastern Region (CRST-Leste), in the city of São Paulo. The city of São Paulo has 06 Reference Centers on Worker's Health (CRST), one in each of the health macro-regions of the municipality: West, Southeast, South, North, Center and East, respectively, having been implanted in the period between 1989 and 1992.

In the first stage of this study, a list and documentary analysis of medical records were obtained in the period from January 1 of 2014 to June 30 of 2015 of workers assisted in this service, and for the selection of subjects for the second stage of the study. The selection criteria were: records of complaints of musculoskeletal and work-related symptoms, with clinical diagnosis established for the group 'soft tissue disorders', of the International Classification of Diseases (ICD-10), and who had experienced withdrawal of work by the INSS due to the disease.

In the second stage, workers were contacted by telephone, and there was an invitation for voluntary participation in the study and scheduling. A script with pre-structured questions for individual interviews was prepared in advance. The interviews were investigated: origin of referrals to the unit, clinical symptoms of the disease during work, search for health care and services, referrals, exams performed, among others. The choice of individual interviews was due to the importance of listening and the possibility of analyzing the individual experiences encountered by the workers. The interviews were held in an appropriate room at the unit in the CRST-Leste and were recorded and transcribed in their entirety, for analysis of thematic content[17]. According to the author, it is a methodologically oriented qualitative research practice, which presupposes some steps: pre-analysis; exploitation of the material or coding; treatment of results; inference; and interpretation. First, there was a floating and exhaustive reading of the testimonies, and, later, the analysis of the data and the definition of the thematic categories.

All the participants signed the Informed Consent Form (ICF). And the research was approved by the Research Ethics Committee of the Federal University of São Paulo (Unifesp), under nº 1.666.746.

Results and discussion

From the first stage, were opened, in the period considered, a total of 642 records, and only 66 were selected, which met the study selection criteria. Of the records analyzed, 66.4% (429) were subjects who performed the function of agents of zoonosis in the East Zone of the city of São Paulo and who were treated at the Unit during this period through the Worker Health and Zoonosis Control Program and Sinatropic Animals (PST CZAS), of the Municipal Health Department, of São Paulo. It is suggested that this data be analyzed in future researches.

Regarding the forms of referral to the service, of the selected medical records, the following were identified: came from the unions (31.8%), health services (19.7%), spontaneous demand (13.6%), citizen's indication (13.6%), among others. The low number of referrals from public health services may indicate the lack of articulation, much needed, with the Health Care Network. From the charts analyzed, most of the subjects were female (60.3%). The fact that women were more affected by RSI/WRMSD

was corroborated in other studies[6,19]. There is no consensus about the reasons, but there are explanations related to the sexual division of labor by gender relations and, also, because of the double working day (15). Still, according to Houvet and Obert6, women seek health services more. The mean age of the subjects was 46.0 years (SD=10.6), with a low level of education (44.0%), being considered low level until incomplete high school. With regard to low schooling, this may be associated with exposure to unsatisfactory working conditions, resulting from job opportunities[3].

From the second stage of the interviews, ten (10) subjects participated, being four (4) of the masculine gender and six (6) of the feminine gender, with ages between 35 and 58 years old. Most of the workers were unemployed at the time of the interviews (6), two (2) were active and two (2) were in a situation of withdrawal from work by the INSS. The time of removal from work by the INSS varied from 1 month to 9 years, where some subjects were, for a long period, in a situation of removal from work (3). The professions were varied. These include: a driver's assistant (1), coordinator of sewing (1), machine operator (1), clerk (1), excavator operator (1), seamstress (1), maid (1), bank (1), general service assistant (1) and kitchen assistant (1).

To preserve the identification of the subjects, fictitious names were used. From the analysis of the interviews, four thematic categories appeared: the worsening of the disease and the demand for assistance; the struggle to prove the disease; the treatments and the biomedical model; and INSS and suffering.

The worsening of the disease and the demand for assistance

The first symptoms reported by the workers were musculoskeletal pain, which they found to be mild, at first, and occurring, usually, during the work tasks or at the end of the working day.

> *[...] it starts with that stabbing pain, and, then, in that case, you're in pain, but you think it's a transient pain.* (Jailson, backhoe loader operator).

Pain, while not imposing any limitation on work activities, was apparently 'naturalized'. Pain is a symptom that cannot be measured objectively and often also refers to work-related suffering. Therefore, accelerated gestures can be defense strategies, and some workers increase productive loads, in an attempt to satisfy the needs of the production context, in search of recognition for work[20].

And when pain began to affect the activities of daily living, including work, subjects began to practice self-medication.

> *[...] Ah, is that what is good for pain? Dorflex, Paracetamol, Voltaren, so that's it ... until I gave up... until the day I arrived and could not comb my hair!* (Eliane, diarist).

Self-medication for relief of painful symptoms and for meeting the demands of work is mentioned in other studies[10,20,21]. And the drugs most used by the interviewees were the anti-inflammatory and muscle relaxants, which are usually the drugs easily obtained in pharmacies.

There is also by workers the fear of being ill and of unemployment, causing them to remain in this condition and, thus, slowing the search for health care.

> *[...] the boss keeps staring as if we were dragging our feet, so you keep working there [...] when it was dismissal time, you knew you could be dismissed.* (Vagner, machine operator).

The fear of unemployment can lead the worker to detach himself from physical and psychic sufferings as well as from his peers, leading to individualism and submission to the risks of work[2]. Collective silence regarding illness and suffering at work is a defense strategy that protects the worker from distress by fear of the consequences of the

disease[13]. With this and in view of the neoliberal and capitalist demands for the maintenance of employment, the cases became worse, without due attention to the health of the workers. In a scenario of greater competitiveness, companies, aiming at reducing production costs, improving the quality of products, services and productivity, invested in technological and organizational changes, which had a negative impact on relations and working conditions[2].

The signs of inability to continue to meet the demands of work began to unfold, with difficulties especially in maintaining the pace of work and quality, generating fear, insecurity and anguish.

> *[...] I was no longer able to tighten the fabric, right? To keep the seam, I told the boss: 'tomorrow I will not come, because I', going to the doctor. My hand is hurting a lot!'.* (Adelaide, seamstress).

Occur, then, the first signs of a patient's identity, marked by the uncertainties about work performance at work and the suffering generated[7]. And in face of the condition and the situation of the subjects with the aggravation of the symptoms and the chronification of the disease, the services of prompt attendance were the main looked for.

> *[...] I used to go to the emergency room, because emergency room you can go at night [...] I went to the emergency room at night. I left work and went to the emergency room with so much pain!* (Paula, bank).

The emergency health service appeared as an important resource used by the subjects, however, with significant limitations when thinking about the need for integral health care, since the care was only aimed at healing the main complaint of the patient, pain. The demand for a prompt service occurred for several aspects, according to the subjects: for some, because it is a possibility of attendance in period/shift out of work; for others, by attending the primary complaint physician, the pain (the exacerbation of chronic pain), occur in a 'fast' way.

In the consultations, there was no recommendation for a longer withdrawal from work activities or restrictions on work activities related to physical stress.

> *[...] At the time of pain, he administered the injection and sent us home, and gave the health certificate of the day and that's it!* (Sabrina, coordinator of the sewing session).

At that time, some physical restrictions could be, perhaps, indicated in some cases, however, the assistances were considered fast, without further clinical investigations and focused on the pathophysiological issue of the disease. The drugs serve the companies as a form of control of the work force, organized by the biomedical model, allowing to extend the working life in the offered working conditions[10]. However, there is a need to pay attention to the health of health professionals, who often feel powerless in relation to what they understand to be the ideal of care, and because they are subject to the biopolitical devices of medicalization[22].

In companies where there were medical outpatient clinics, some workers had access to medicalization.

> *[...] I went there to take medicine for muscle pain. The doctor does not give you examination. I used to tell them about the pain in here... so they did not give exams.* (Vagner, machine operator).

Minimizing the deleterious effects of working conditions and the execution of painful activities, the attendances also occurred in order to medicalize the pain, without deepening about possible causes related to work. The companies have private control of the health and safety of workers, from the specialized services in Safety Engineering and Occupational Medicine

(SESMT). With the minimum participation of the State in this control, the SESMT teams are subordinate to the will and the command of the employer to perform their functions, based on the neoliberal perspective[10]. "Medicalizing pain can still be understood as a way of disqualifying suffering in favor of production"[13(158)]. In addition, the demand for medicines directs the care flow only to the medical professional, devaluing multidisciplinary actions[10].

The struggle for the proof of the disease

With the frequency of services in emergency assistance and the chronicity of symptoms and illness, there was a need for further investigation with clinical exams. The accomplishment of these examinations was the initial process for the legitimation of the disease.

> *[...] The doctor (orthopedist) had the resonance done, when he saw that my problem was serious, that I could not go back to work. That's when he pulled me away.* (Esmeralda, kitchen assistant).

All workers had clinical tests whose results proved their illnesses and therefore 'justified' their painful complaints, legitimizing them. The relentless pursuit of credibility related to the complaints was evident among the participants, given the importance of granting social security benefits. The feeling of distrust of health professionals generates tensions among the actors involved, rendering unfeasible therapeutic strategies that are fundamental for care, reception, bonding and co-responsibility for treatment[22]. Therefore, from the finding and proof of the disease and its severity, by an orthopedic doctor, the work withdrawn by the INSS occurred.

Those who had assistance exclusively from SUS had difficulty accessing a specialist quickly, due to the delay in obtaining a consultation schedule.

> *[...] I stood in a queue waiting for the orthopedist during 1 year and 6 months. Is there any way you can do this treatment if you wait for so long? [...] then, I went to the private one, that I paid, it was when I did these exams.* (Eliane, diarist).

This information corroborates the study of Dal Magro, Coutinho and Moré[22], who reported that between waiting for scheduling medical consultations and conducting examinations, workers continue to use drugs and remain exposed to occupational hazards, which further aggravates the disease. Still, the delay in scheduling generated suffering, given the importance of health care to guarantee their rights. Thus, from the examinations and the proof of the disease, the subjects were moved away from work by the INSS.

Some workers, through the denial of the CAT registration by the company, sought, then, assistance at the CRST-Leste, site of this study.

> *[...] he* [colleague of the union] *said to me: 'Paula, see if you cannot register a CAT'. He gave me the address from here [...] because the banks, they do not give sequence, they do not assume that you suffered this as an accident at work!* (Paula, bank).

In addition to proving the clinical diagnosis, there was a need to recognize the relationship between the disease and work, and, for this, the CAT should have been issued by the company. The fact that RSI/WRMSD appear insidiously and present a multifactorial etiology may contribute, in general, to the non-registration of this statement (CAT). In addition, companies do not want to admit, in general, the relation between the causal link of work and the disease, leaving the worker with the task of seeking some evidence. The denial of CAT is a reality in the Country, which can be inferred from

the fall of its registry from 2007[23]. Probably, this fact occurs to avoid the burden with the Accident Prevention Factor (FAP), in which companies tend to under-reporting of occupational accidents, especially occupational diseases. In addition, with the issue of CAT, the worker is guaranteed 12 months of stability in the company after returning to work. The FAP is the calculation of insurance paid by the company to pay for special pensions and benefits arising from work accidents. The companies that register the greatest number of occupational accidents or diseases pay more, on the other hand, they subsidize the companies that register minor risk of accident[16]. By denying the issue of the CATs, they are denying the influences of the ways of organizing work in the sick.

The treatments and the biomedical model

In general, initial treatment for RSI/WRMSD was related to medical care and referral to Physiotherapy.

> *[...] I waited for, approximately, 1 hour to be treated and stayed about 2 minutes in the office. So, he [orthopedic doctor of the covenant] just indicated me physiotherapy, which was already there in the computer.* (Francisco, clerk).

According to the statements, regardless of the type of service, whether private, public or covenant, and the medical specialty, the conduct was similar with regard to the time of service (brief) and drug prescriptions, examination reviews and new requests (if necessary), as well as referral to physiotherapy and/or surgery, according to the stages of the disease and the specificities of the cases. The psychosocial aspects involved and often found in the situation of withdrawal from work and in the process of rehabilitation of chronic cases were not addressed nor did they generate referrals to other professionals trained to meet these demands.

Still, some workers described a flow of physical rehabilitation with no possibility of continuity, due to difficulties in scheduling, especially for those who had access to health exclusively through SUS.

> *[...] I spent 1 year and 2 months waiting for the physiotherapy vacancy, then I get there for four weeks of physiotherapy, twice a week, and it's over, and you leave, there's nothing you can do!* (Eliane, Diarist).

The flow of assistance was based on a model of care by medical indication, focused on the remission of painful symptoms of the disease. When there is no care line, the user makes his own way through the service networks, being this practice highly perverse, which can lead to errors and induce the consumption of procedures focused on exams and medicines, producing high costs[24]. Moreover, it is a barrier to return to work[25]. And the fragmentation of health actions is a reflection of the specialization of knowledge[9]. Health care, therefore, conceals the production of work-related illness, taking the opportunity of workers to reveal the social precariousness produced by capital.

INSS and suffering

In the testimonials, the subjects reported on the ways of attending the medical experts.

> *[...] He did not even give it to me, he threw it! He looked up and said: 'What is this here?' and threw* [exams]*! And he said, 'Wait for the result out there'.* (Yara, cleaning assistant).

There were complaints of situations where there were conflicting relationships and 'disregard' with the insured, corroborating other studies[7,21]. In the expert examination, the procedure was to consult reports, reports and medical examinations, in an apparently superficial way, and triggered feelings of revolt and indignation, as well as

the fear of the final result of the care (of the question of being able or not to work).

Moreover, the establishment of the causal nexus, through the recognition of the CAT in the INSS, was also cause for distress and suffering.

> *[...] then, I was not recognized because the INSS, the doctor, nor the papers nor the examination she looked at. She didn't consider it, she did not look at anything.* (Vagner, machine operator).

When there is recognition by the INSS, in this case, of the RSI/WRMSD, of the occupational disease, the worker receives the accidental sickness benefit (B91) and is entitled to one year of stability in the company, which does not occur when receiving the social security sick pay[16]. Of the interviewees, only half (n=5) received the accident illness aid.

There was also outrage over their physical limitations to work, and the workers felt humiliated and wronged.

> *[...] ah, you feel humiliated, right? It's awful! 'This is only a partial injury, and you can work'* [expert]. *It's my arm that hurts... It's me who feels the pain!* (Marcos, truck helper).

There was an apparent mistrust of the experts regarding the real situation of physical commitment to work, referring again to the reductionist view of the biomedical model, without considering the psychosocial issues involved. The assessment of work incapacity focused on the biomedical model can reinforce and influence the need for fragmented and reductionist actions in the rehabilitation process[11,25]. Still, even with the subjects carrying exams and reports of physicians proving the disease, these documents were not considered, demonstrating the impasses between the reports obtained from the health sectors and those from the social security. Thus, the workers removed from work are constantly questioned in the expertise, generating feelings of impotence, embarrassment and humiliation.

Conclusions

Therapeutic pathways, in most cases, began with self-medication, which was a strategy to 'silence' pain and suffering, for fear of unemployment and losing the social status of an active worker, among others. The search for a medical assistance occurred only when the clinical picture was already more aggravated, evidencing the preferential search of an emergency service to soften the symptom limiting the work: pain. The symptom was, in most cases, treated with the prescription of analgesics and anti-inflammatories, characterizing the medical-assistance model directed to the problematic of the prescription of medicines and attending to the biomedical model, in situations where there was already aggravation of cases already chronic, leading, perhaps, to a late search for laboratory tests. Featuring, even, an individual course, for a health problem produced collectively.

There were also difficulties in proving the disease and in the search, by the worker, for information about the opening of the CAT. And among the workers who had medical agreements and those who exclusively used the SUS, there were differences especially regarding the waiting time for consultations with specialists and for the conduct of examinations. In the clinical and rehabilitation procedures, the approach was based on the biomedical model, not meeting the psychosocial demands involved in the chronic disease processes. There were situations of humiliation during the expertise of the INSS and helplessness by the companies, causing suffering. In addition, the INSS assessment of incapacity for work also requires revisions.

There is a need for integrated actions with health, social security and companies, so that improvements can occur in the processes of rehabilitation of workers in situations of withdrawal from work by RSI/WRMSD. It is also important to pay attention to public policies, so that they are more incisive in the accountability of companies for the production of illness at work. However, to act in the relations between capital and labor presupposes to act in conflict with the relations of political and business power, the latter aim primarily at the profit, often at the expense of exploitation of the labor of workers. In addition, there is little state intervention in the market, as neoliberalism presupposes. These are issues that, among others, are posing great challenges in the field of worker health.

This study had limitations with regard to the low sample, since it refers to a regional population, and therefore cannot make generalizations of the cases. However, it was intended to emphasize and reflect on the difficulties encountered by the subjects affected by RSI/WRMSD. It is hoped that future studies will deepen discussions and, especially, promote improvements in the integral health care of workers affected by RSI/WRMSD.

Collaborators

Camilla de Paula Zavarizzi participated in the project, obtaining, analyzing, discussing and interpreting the data, as well as elaborating and revising the manuscript.

Maria do Carmo Baracho de Alencar coordinated and oriented the research, participating in the analysis, discussion and interpretation of the data, besides the elaboration and revision of the manuscript. ■

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