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REFACS

Analysis of the work of oral health teams from an interprofessional perspective

Análise do trabalho das equipes de saúde bucal na perspectiva interprofissional

Análisis del trabajo de los equipos de salud bucodental desde la perspectiva interprofesional

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This is a cross-sectional study with a quantitative approach carried out in Recife, in the state of Pernambuco, Brazil, in 2019. It aimed to analyze the work of oral health teams in primary care, in an interprofessional perspective. The sample was selected by drawing a team by micro-region, among the three existing ones. The interviews were face to face, aided by a structured questionnaire. The analyzes were descriptive and inferential. Six dental surgeons and nine oral health technicians and assistants were interviewed. There was integration of teams in common actions with other members of the unit (100%), being lower in territorialization (33%). There was satisfactory collaboration (66.7%) of other team members in oral health actions. They considered the integrated participation in planning (83.3%) to be common to reach (66.7%), make decisions independently (100%), but the type of relationship prevailed in the work of personal and professional communication (66.7%), classified as intermediate. It is concluded that the interviewees carry out the integration, however, communication is not complete.
Descriptors: Oral Health; Primary Health Care; Interprofessional Relations.

Este é um estudo transversal de abordagem quantitativa realizado em Recife - PE, em 2019, e teve como objetivo analisar o trabalho de equipes de saúde bucal da atenção primária, na perspectiva interprofissional. A amostra foi selecionada por sorteio de uma equipe por microrregião, dentre as três existentes. As entrevistas foram face a face, com questionário estruturado. As análises foram descritivas e inferenciais. Foram entrevistados seis cirurgiões dentistas e nove técnicos e auxiliares de saúde bucal. Observou-se integração das equipes em ações comuns com demais membros da unidade (100%), sendo menor na territorialização (33%). Houve colaboração satisfatória (66,7%) de outros membros da equipe em ações de saúde bucal, consideraram importante a participação integrada no planejamento (83,3%) para alcances comuns (66,7%), tomam decisões com independência (100%), mas predominou o tipo de relacionamento no trabalho de comunicação pessoal e profissional (66,7%), classificado como intermediário. Conclui-se que os entrevistados realizam a integração, contudo, a comunicação não é plena.
Descritores: Saúde Bucal; Atenção Primária à Saúde; Relações Interprofissionais.

Este es un estudio transversal de enfoque cuantitativo realizado en Recife - Pernambuco, en 2019, cuyo objetivo fue analizar el trabajo de los equipos de salud bucodental de atención primaria, en la perspectiva interprofesional. La muestra se seleccionó sorteando un equipo por microrregión, entre las tres existentes. Las entrevistas fueron cara a cara, con un cuestionario estructurado. Los análisis fueron descriptivos e inferenciales. Se entrevistó a seis cirujanos dentistas y a nueve técnicos y asistentes de salud bucodental. Hubo integración de equipos en acciones comunes con otros miembros de la unidad (100%), siendo menor en la territorialización (33%). Hubo una colaboración satisfactoria (66,7%) de otros miembros del equipo en acciones de salud bucodental, se consideró importante la participación integrada en la planificación (83,3%) para logros comunes (66,7%), tomar decisiones de forma independiente (100%), pero predominó el tipo de relación en el trabajo de comunicación personal y profesional (66,7%), clasificado como intermedio. Se concluye que los entrevistados realizan la integración, sin embargo, la comunicación no es plena.
Descriptores: Salud Bucal; Atención; Primaria de Salud; Relaciones Interprofesionales.

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INTRODUCTION

In the context of the reorganization of Primary Health Care (PHC) in Brazil, several changes were made with the purpose of establishing comprehensive care, through the reorganization of health practices that require an interprofessional approach, with a view to reaching a model centered on the territory and the health needs of the population[1,2].

In this perspective, PHC requires the work of multiprofessional teams to face the compartmentalization of practices carried out by professionals from different areas and levels of education, thus favoring interprofessional collaboration[2,3]. In this view, teams have been constituted as work units, and no longer individuals in isolation, requiring new ways of dealing with people and taking care of organizations[4,5].

However, professional resistance is observed due to the work process of intense specialization in the health area, as an expression of the biomedical care model, which is still persistent. Different studies point out that professional work practices in PHC are carried out in a fragmented and disjointed manner without integrality in health care from the perspective of the work of the Family Health Team or have revealed that integration is limited by work overload problems; charging for achieving goals in the logic of productivity[6,7], lack of infrastructure, lack of planning and lack of interaction between workers[5,7].

In the oral health area, one of the challenges faced by dental professionals who work in the Family Health Strategy (FHS) are the difficulties in their integration in the work of the multiprofessional team[8], or identifying an integration of oral health teams (OHT) with the incipient family health teams (FHT)[9].

In view of the need to break with the development of fragmented work and recognize the potential of interprofessional practices in improving quality of care in the Unified Health System (SUS) and in the qualification of health professionals, research on the relationships and type of work carried out by OHT, in an integrated perspective, in order to provide contextualized information on the evolution of this integration requested from professionals working within the PHC scope.

Interprofessionality is an answer to fragmented health practices, being developed through cohesive practice among professionals from different disciplinary fields with a focus on the needs of user, family and community[10]. It is argued that the development of interprofessionality does not happen spontaneously, being necessary a series of measures that offer support in this new interprofessional action in the daily routine of services[11]. It requires a paradigm shift in terms of values, codes of conduct and work processes[12].

To analyze the work process of the health teams carried out in the SUS health care network, different approaches are presented by studies carried out especially in the FHS[7,13]. Peduzzi (2001)[14] proposes a method for analyzing the type of work of Basic Health Care teams (type of integration team or group team), which aims to identify the existence of interprofessionality in the performance of the teams.

Interprofessionality is anchored in teamwork as a collective modality, configured in the reciprocal relationship between technical interventions and interaction. Thus, this study aimed to analyze the work of oral health teams in primary care, in the Interprofessional perspective.

METHODS

This is a cross-sectional study with a quantitative approach developed in the Sanitary District IV (DSIV), of the Health Department of Recife, in the state of Pernambuco, located in the west of the city[15]. The territory is divided into three health micro-regions, where there are 20 family health units (FHU), 40 FHT and 26 OHT. Of those, 07 OHT were classified as Type II, with the 03 professionals: dental surgeon (DS), oral health technician (OHTec) and oral health assistant (OHA); and 19 were classified as Type I, with only 02 DS and OHA.

The sample was of convenience and, in the selection, it was decided to draw two OHT from each of the three micro-regions of the DSIV, regardless of Type. OHTs in which all members had been executing their functions for more than a year were included.

Data collection was carried out in the first semester of 2019, through individual structured interviews (face to face) in an indicated and reserved place in the FHU. The interview tool (questionnaire) was preceded by a bibliographic review and based on Peduzzi's theoretical reflections on interprofessional work[14].

The instrument was organized in two blocks. The first block consisted of sociodemographic and professional variables, and the second block consisted of variables on the work process of the OHT and its interfaces with the FHT. The choice of variables in this second block to analyze the integration between members of the OHT and FHT, were based on parameters recommended by Peduzzi[14] for the recognition of the integration teamwork method. This instrument had face validation performed by two specialists.

Still in the second block, most questions were formulated for the DS, which is responsible for coordinating the activities of the other members of the OHT, in order to verify their suitability for interprofessional work, given the persistence of individualizing practices in this profession[8, 9].

Data analysis was done through descriptive and inferential statistics. Absolute and relative frequency distribution were obtained for categorical and measure variables: mean, standard deviation and median for numerical variables.

For the comparison between the professional categories (DS, OHTec or OHA), Fisher's exact test was used for the categorical variables and the Mann-Whitney test for the comparison of the numerical variable. The Mann-Whitney test was chosen due to the number of DSs. For these analyzes, the significance level of 5% was adopted. Data entry and statistical calculations were performed in Microsoft Excel spreadsheets, version 2007, and the program used to obtain statistical calculations was IMB SPSS in version 23.

The research project was approved by the Research Ethics Committee of the Health Sciences Center of the Universidade Federal de Pernambuco, under Opinion No. 2,965,560.

RESULTS

15 professionals participated, being: six DS, three OHTec and six OHA, members of six OHT. Table 1 shows the sociodemographic and professional characterization of the interviewees. There was a predominance of females (66.7%) among DSs; all OHTec and OHA were female. Regarding age, the participating DSs were between 31 and 69 years old, while the OHTec and OHA ranged from 32 to 69 years old.

Regarding the type of employment bond, 100% of the DS had a permanent employment bond in the public service, and 88.9% of the OHTec and OHA are in this condition. Only one OHTec operates under a contract. The length of professional practice at PHC in Recife ranged from 5 to 11 years, and had an average of 8.50 years among DSs and 9.17 years among other OHT professionals (Table 1).

As for having some training in family health, 33.3% of the DSs reported having specialization, whereas only 11.1% of OHTec and OHA said they had it. Regarding the educational level of OHTecs and OHAs, a high school level was predominant (55.6%), followed by higher education (22.2%) (Table 1). For the fixed margin of error (5%), there were no significant differences ($p \leq 0.05$) between the two categories for any of the variables under analysis.

Table 1. Sociodemographic and professional characterization of the interviewees. Recife, PE, 2019.

Variables	Oral Health Teams				
	Dental Surgeons		Oral Health Technicians and Assistants		
	Frequency		Frequency		
	n	%	n	%	
Gender					p = 0.143
Male	2	33.3	-	-	
Female	4	66.7	9	100.0	
Age group					p = 1.000
31 to 39 years	3	50.0	4	44.4	
40 to 63 years	3	50.0	5	55.6	
Time in the profession					p = 0.119
5 to 10 years	5	83.3	3	33.3	
More than 10 years	1	16.7	6	66.7	
Type of employment bond					
Permanent	6	100.0	8	88.9	p = 1.000
Contract	-	-	1	11.1	
Especialization/ capacitation*					
Family Health	2	33.3	1	11.1	p = 0.525
Educational level -TSB/ASB					
High school	-	-	5	55.6	**
Incomplete higher education	-	-	1	11.1	**
Higher education	-	-	2	22.2	*
Masters degree	-	-	1	11.1	*

Note: * Frequency for the 2 surveyed among dentists who had a specialization in Family Health and 1 surveyed among technicians and assistants with training in family health. ** It was not determined due to the lack of classification of dentists.

All participants reported integration between teams. Regarding the participation of OHT in activities at the FHT, the following activities were observed: reception (DS: 83.3%; OHTec and OHA: 100%), prenatal care (DS: 83.3%; OHTec and OHA: 77.8%), childcare (DS: 16.7%; OHTec and OHA: 55.6%), vaccination (DS: 100%; OHTec and OHA: 0%), inter-consultation (DS: 50.0%; OHTec and OHA: 44.4%), groups of pregnant women (DS: 66.7%; OHTec and OHA: 66.7%), HIPERDIA group (DS: 83.3%; OHTec and OHA: 77.8%), other groups in health education (DS: 83.3%; OHTec and OHA: 44.4%), team meetings to discuss the clinical case (DS: 83.3%; OHTec and OHA: 66.7%), participation in the elaboration of a singular therapeutic project (STP) (DS: 20%; OHTec and OHA: 0%). In external activities, in the territory, home visits were the most frequent (DS: 66.7%; OHTec and OHA: 77.8%), followed by intersectoral action and clinical-home care, which obtained the same percentage values (DS: 50.0%; OHTec and OHA: 33.3%), and it was the territorial activity that obtained the lowest values of integrated participation of OHT with FHT (DS: 33.3%; OHTec and OHA: 11.1%) (Table 2).

Among FHT members participating in OHT activities, it was stated that all community health agents (CHA) develop activities with oral health professionals, followed by doctors (50.0%), nurses (50.0%) and nursing technician (50.0%). Regarding matrix activities, 50.0% of the interviewees stated that there was a request from the FHT for oral health matrix. Being perceived by all respondents a good degree of interest from the FHT when performing matriculation by the OHT and there was a satisfactory assessment (66.7%) on the FHT integration in oral health activities (Table 2).

Table 2. Joint actions of OHT and FHT in the FHU surveyed. Recife - PE, 2019.

Variable	Oral Health Team				
	Dental Surgeons		Oral Health Technicians and Assistants		
	Frequency		Frequency		
	n	%	n	%	
Integration of EqSB's actions with EqSF					
Yes	6	100.0	9	100.0	*
No	-	-	-	-	
FHU Activities					
Reception	5	83.3	9	100.0	p = 0.400
Prenatal care	5	83.3	7	77.8	p = 1.000
Childcare	1	16.7	5	55.6	p = 0.397
Vaccination	6	100.0	-	-	p < 0.001**
Clinical care (Interconsultation)	3	50.0	4	44.4	p = 1.000
Groups of pregnant women	4	66.7	6	66.7	p = 1.000
HIPERDIA group	5	83.3	7	77.8	p = 1.000
Other health education groups	5	83.3	4	44.4	p = 0.287
Team meeting to discuss clinical care	5	83.3	6	66.7	p = 0.604
Realization of singular therapeutic project - STP	1	20.0	-	-	p = 0.400
Activities in the territory					
Home visits	4	66.7	7	77.8	p = 1.000
Clinical home care	3	50.0	3	33.3	p = 0.622
Territorization	2	33.3	1	11.1	p = 0.525
Intesectoral action	3	50.0	3	33.3	p = 0.622
Others	1	16.7	9	100.0	p = 0.002**

Note: *Values not informed, it was not determined due to the occurrence in only one category. ** Significant difference <5%.

In Tables 3, 4 and 5, results are presented whose information was provided only by the Dental Surgeon of the studied OHT. In Table 3, it is observed that 50% of the DS stated that they regularly consult with other members of the FHT, 83.3% do home visits, 50.0% perform group activities (permanent and/or continuing education) and 83.3% perform health promotion and education activities. However, the majority (66.7%) rarely carry out activities aimed at students in conjunction with FHT. However, they always carry out planning activities in a situation room (50.0%), administrative meeting (66.7%) and registration and territorialization (50.0%).

Table 4 shows the results on the existence of FHT participation in oral health activities. It was found that the OHT request the participation of the FHT, and this attitude of seeking collaboration by the FHT was considered satisfactory by most respondents (66.7%). The majority (83.3%) stated that FHT participate in activities developed by OHT. Integrated participation in reception activities for scheduling dental appointments (40%) and dental prenatal care (40%) were the most mentioned.

Table 3. Joint activities between OHT and FHT Recife, PE, 2019.

Variables	n	%
Consultation in the unit (Interconsultation)		
Always	2	33.3
Usually	3	50.0
Rarely	1	16.7
Never	-	-
Home visit		
Always	-	-
Usually	5	83.3
Rarely	1	16.7
Never	-	-
Group activities		
Always	2	33.3
Usually	3	50.0
Rarely	1	16.7
Never	-	-
School activities		
Always	1	16.7
Usually	1	16.7
Rarely	4	66.7
Never	-	-
Situation room planning		
Always	3	50.0
Usually	2	33.3
Rarely	1	16.7
Never	-	-
Administrative meeting		
Always	4	66.7
Usually	2	33.3
Rarely	-	-
Never	-	-
Permanent and/or continuing education		
Always	1	16.7
Usually	3	50.0
Rarely	2	33.3
Never	-	-
Registration and territorialization		
Always	3	50.0
Usually	2	33.3
Rarely	1	16.7
Never	-	-
Health promotion and education activities		
Always	1	16.7
Usually	5	83.3
Rarely	-	-
Never	-	-

Table 4. Integrated participation of FHT in the activities of OHT, Recife, PE, 2019.

Variables	n	%
OHT seeks collaboration from FHT		
Very satisfactory	-	-
Satisfactory	4	66.7
Indifferent	-	-
Little satiscation	2	33.3
Low/no participation	-	-
FHT participates in OHT activities		
Yes	5	83.3
No	1	16.7
Types of participation* (1)		
Dental care (interconsultation)	1	20.0
Educational lectures on oral health	1	20.0
Reception (scheduling dental appointments)	2	40.0
Oral health promotion	1	20.0
Home visits	1	20.0
Dental pre-natal care	2	40.0
Active search (or health issues)	1	20.0
FHT members participating		
Community Health Agent	2	100.0
Doctor	1	50.0
Nurse	1	50.0
Nursing technician	1	50.0
OHT performs oral health matrix suppport for FHT		
Yes	3	50.0
No	3	50.0
OHT's perception of fht interest in matriculation		
Very good	-	-
Good	3	100.0
Indifferent	-	-
Poor	-	-
Very poor	-	-
Evaluation of FHT integration in oral health activities		
Very satisfactory	-	-
Satisfactory	4	66.7
Indifferent	-	-
Little satiscation	2	33.3
Low/no participation	-	-

Note: * (1) considering that the same surveyed could cite more than one activity, the sum of frequencies is higher than those surveyed.

Table 5 presents the results on the interviewees' view regarding aspects of communication between the members of the FHU for an action consistent with the guidelines of the *Política Nacional de Atenção Básica à Saúde* - PNAB (National Policy for Primary Health Care). The degree of communication between FHU members was considered very good by half of the interviewees. Regarding the type of relationship between the members of the FHU, an intermediate type relationship prevailed (66.6%).

Only 33.3% of the respondents stated that there was full communication between them, focused on achieving health outcomes for the population. But the majority responded acting on a common health care project (66.6%), knowing the assignments defined by the PNAB for each member of the FHT (66.7%) in addition to assigning a very important degree for the participation of each member of FHT in the planning of FHU actions (83.3%). All respondents stated that they carry autonomicaly out their activities (independence in execution and decision-making at work).

Table 5. Integrated teamwork. Recife, PE, 2019.

Variable	n	%
Degree of communication between FHU members		
Very good	3	50,0
Good	1	16,7
Indifferent	1	16,7
Poor	1	16,7
Very poor	-	-
Type of relationship between FHU members		
Restricted to professional matters	-	-
Predominantly personal, by affinities	-	-
Full communication, with goals, proposals and targets to be achieved for the target population	2	33,3
Intermediate (in between professional and personal communication)	4	66,7
Performance on a common health care project		
Yes	4	66,7
No	2	33,3
Knowledge of the assignments defined by the PNAB for each member of the EqSF		
Yes	4	66,7
No	2	33,3
Degree of importance of EqSF members in action planning		
Very importante	5	83,3
Important	-	-
Indifferent	-	-
Little important	-	-
Not important	1	16,7
Independence in execution and decision-making at work		
Yes	6	100,0
No	-	-

DISCUSSION

The results of this study indicate that the interviewed OHT seek integration from the other team members when performing their activites.

The characterization of the participating subjects showed a predominance of females. This is consistent with other studies that have observed the feminization process of the DS, OHTec and OHA professions[16,17].

Regarding age and time of professional practice, results indicated the existence of a workforce with greater experience in acting in the OHT of the DSIV of Recife. This corroborates another similar study carried out with the DS of this DSIV[18] and another carried out in Santa Catarina with OHTec[17].

Most had some type of family health education, which corroborates another study carried out at PHC in Recife with dental surgeons[19]. This finding may be related to the expansion of job offers for oral health professionals, favored from the implementation of the National Oral Health Policy in 2004[20], and which was accompanied by the expansion of the health care network and oral health in Recife[15].

Most interviewees work under a permanent employment bond. The type of employment bond is a factor that favors good performance and satisfaction and greater effectiveness in the requested work process than those who work on a temporary basis, which tend to restrict their care activities[18].

The teamwork recommended for PHC assumes that professionals carry out interventions specific to their respective areas, but are also required to carry out shared and common actions, which are integrated with knowledge from different fields[13].

In this study, there was an integrated participation of all members of the OHT, who reported sharing the execution of different common actions of the FHT, which are already planned since the beginning of Family Health[1,2], such as reception activities, prenatal care,

groups of pregnant women, HIPERDIA and health education, as well as home visits and clinical care and intersectoral actions. However, despite the *Projeto Terapêutico Singular* - PTS (Singular Therapeutic Project) being an instrument that enhances interprofessional practice, the participation of the interviewees in the elaboration of this one was insignificant, even though the majority claimed to participate in a team meeting to discuss the clinical case.

These results corroborate another similar research, which highlighted the integration of oral health professionals in team meetings, home visits, intersectoral actions and health education groups[9]. However, they diverge from other studies that identified difficulties in integrating OHT in the work of multidisciplinary teams[8,9], which are related to late insertion in the FHU and resistance to replace very technical and self-centered biomedical practices by the comprehensive and integrated care required by Basic Health Care[20 , 21].

In addition to these findings, it was reported that the execution of actions carried out with members of the FHT are common. But the lack of integration in activities with schoolchildren drew attention. This suggests that there is no program for the activities of the School Health Program for public schools belonging to the FHU territories of the interviewees, whose purpose is to promote joint interventions between the FHT and OHT and the schools, to enhance actions outlined by comprehensive health care policies for children and adolescents[22].

The participation of FHTs in oral health activities was considered collaborative and satisfactory. These results are consistent with national efforts to promote comprehensive health care provided by multiprofessional Basic Health Careteams. An integrative review identified some concern of oral health professionals in ensuring access and quality of prenatal oral health care to pregnant women with a view to comprehensiveness[23]. In this context, the awareness of the multiprofessional team on maternal and child oral health enables other forms of care for professionals in the practice of comprehensive oral health care[23].

However, an investigation carried out at the PHC in Recife showed that dental care is predominantly carried out by the OHT[24]. And, another study that investigated interprofessional collaboration among prenatal care professionals, identified in the municipality of Uberlândia, in the state of Minas Gearis[25], subjective barriers to the implementation of protocols that would require a greater degree of collaborative work. Emphasizing that a simple action by the multidisciplinary team to direct pregnant women to prevent and control periodontal disease can reduce adverse pregnancy outcomes, such as prematurity and low birth weight[25].

It is considered that the quality of communication and interaction between members of health teams are essential to the improvement of quality in comprehensive care to the health needs of users, and a reciprocal relationship with each other should be pursued communication and interaction[26].

In this study, half of DSs considered that there was a very good degree of communication between them and the other members of the FHT for carrying out collaborative practices. However, a type of relationship with co-workers prevailed, in which communication sometimes happens due to personal affinities, sometimes is restricted to professional issues. These results agree with another study carried out in the Brazilian Federal District, which identified integration between OHT and other intermediate level FHT professionals[9]. Furthermore, an communication inherent to work, focused on the articulation of actions and the integration of agents, is considered an important characteristic of an integrated team[14].

At the same time, there was an intention of interviewees to act in accordance to the joint assistance project planned jointly, with interprofessional collaboration, with the majority having knowledge about the attributions of each member of the team and considering the participation of each FHT member as very important.

This suggests an alignment of the interviewees with the guidelines for the work of Basic Health Care in Recife[27] and in Brazil[1] itself, in contrast to professional practices linked to the biomedical model, which is still predominant. Furthermore, acting collectively on a common

project to respond to the multiple dimensions of the health-disease process in a health territory is one of the criteria used to characterize an integration team[14].

In contrast with this result, other studies continue to identify work processes in PHC organized in a fragmented way, with fragile axis, observed within the health[10] and oral health teams, with a tendency to follow a model centered on the individualization of actions[8,9].

Professional autonomy must be conceived as the sphere of freedom of judgment and decision-making in view of the health needs of users, being recognized as subjects of the work process, professionals exercise technical autonomy.

All respondents considered exercising their functions with autonomy in the execution and decision-making at work, which strengthens communication and integration among team members, as in other Brazilian experiences[13,14] and other international ones[3,4,26]. However, problems of hierarchical work and the type of management that hinder the autonomy of the team and the professional are identified[6]. A study, carried out in five municipalities in the Metropolitan Region of Grande Vitória, in the state of Espírito Santo, showed that the relationship between the health team and the DSs with OHTec is uneven and they have little autonomy[6].

In Brazil, a study carried out on the management of work carried out in the FHS identified actions aimed at innovating the ways of working as the greatest challenge, through spaces for horizontalized and participatory dialogues, which are in fact intended to induce changes in working relationships between managers and professionals with a view to establishing - in the daily practice of health - co-management for decision-making[28]. Another international study identified barriers to Interprofessional work, aspects related to awareness of professionals about this type of work, sharing of information and problems related to training, financing and long-term monitoring of teams[28].

CONCLUSION

When considering these results, it was evident that the practices of the professionals of the OHT and FHT are taking place in the perspective requested for the interprofessional work, but the communication between professionals is not complete. Also, professionals are executing their practices in line with the competencies and duties required of PHC.

As a limitation of this study, one must consider the low external validity, as it was carried out in a sample of only one health district and a questionnaire applied had not been validated. On the other hand, methodological care was taken in the construction and application of the data collection tool, seeking results that would in fact express the opinion provided by the participants, minimizing information bias. In addition, studies aimed at similar populations are needed to confirm these findings.

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Andreza Andrade Moura Silva contributed to the design, collection and analysis of data and writing. **Cynthia Maria Barboza do Nascimento** participated in the writing and reviewing. **Márcia Maria Dantas Cabral de Melo** collaborated in the design, writing and reviewing.

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