Original Article

Popular practices and beliefs in childcare: perceptions and behaviors of Primary Health Care nurses

Práticas e crenças populares no cuidado infantil: percepções e condutas de enfermeiras da Atenção Primária

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ABSTRACT

Objective: to understand the role of Primary Health Care nurses in relation to popular practices and beliefs in children's health care. **Methods:** qualitative study conducted with nine nurses in four Family Health Strategy units. Data were collected through semi-structured interviews guided by a script of open- and closed-ended questions. Content analysis was used. **Results:** organized into two thematic categories: Nurses' perceptions of popular practices and beliefs related to children's health, and Nurses' conduct in addressing cultural practices in children's health: strategies for action. Professionals recognize the use of popular practices and understand their historical and cultural construction. They use strategies such as adapted communication, bonding, and health education to act. **Conclusion:** nurses manage popular beliefs in childcare through dialogue and bonding, highlighting childcare as a space for negotiating knowledge. This expands the role of nursing in culturally sensitive care in Primary Health Care. **Contributions to practice:** the inclusion of this theme during undergraduate studies and in continuing education spaces can contribute to the training of professionals and the protagonism of subjects in therapeutic processes.

Descriptors: Child Health; Child Care; Nursing; Medicine, Traditional; Primary Health Care.

RESUMO

Objetivo: conhecer a atuação de enfermeiras da Atenção Primária à Saúde sobre as práticas e crenças populares na atenção à saúde das crianças. **Métodos:** estudo qualitativo desenvolvido com nove enfermeiras em quatro unidades de Estratégia Saúde da Família. Os dados foram coletados por meio de entrevista semiestruturada, guiada por um roteiro de perguntas abertas e fechadas. Utilizou-se a análise de conteúdo. **Resultados:** estão organizados em duas categorias temáticas: Percepções das enfermeiras sobre as práticas e crenças populares relacionadas à saúde da criança e Condutas das enfermeiras na abordagem de práticas culturais na saúde da criança: estratégias de atuação. Os profissionais reconhecem o uso de práticas populares e compreendem sua construção histórica e cultural. Utilizam-se de recursos como comunicação adaptada, vínculo e educação em saúde como estratégias de atuação. **Conclusão:** as enfermeiras manejam as crenças populares no cuidado infantil por meio de diálogo e vínculo, destacando a puericultura como espaço de negociação de saberes. Isso amplia o papel da enfermagem no cuidado culturalmente sensível na Atenção Primária à Saúde. **Contribuições para a prática:** a inclusão dessa temática durante a graduação e em espaços de educação permanente podem contribuir para a formação dos profissionais e o protagonismo dos sujeitos nos processos terapêuticos.

Descritores: Saúde da Criança; Cuidado da Criança; Enfermagem; Medicina Tradicional; Atenção Primária à Saúde.

Introduction

The intersection between family and nursing care plays a crucial role in children's health. For comprehensive care, nurses must value popular beliefs and practices alongside scientific knowledge, respecting and understanding family traditions through open and welcoming dialogue[1].

Family care is marked by beliefs, customs, practices, and knowledge derived from the cultural context. Popular practices are measures and/or resources used by families, based on empirical knowledge of daily life, transmitted between generations. Beliefs, in turn, derive from common sense and reflect the experiences of each social group[2].

Adherence to popular practices in childcare is evident among families, stemming from the sharing of experiences among family members and social groups, which influences the development and growth of the new member[3]. Childhood is a decisive stage of human development, marked by intense learning and physical, emotional, and social growth, which contributes to the formation of a person's personality and skills. Adequate care at this stage of life contributes to disease prevention, health promotion, and the reduction of social inequalities[4].

The Brazilian Unified Health System (SUS), through the National Policy for Comprehensive Child Health Care, seeks to ensure comprehensive care for early childhood and vulnerable populations. In line with this, the National Policy for Popular Education in Health (PNEPS-SUS, acronym in Portuguese), established in 2013, values dialogue between knowledge and popular practices, strengthening the work of teams in the territories. In this context, Primary Health Care (PHC) is the main reference in child[5-6] and family care, with emphasis on the Childcare Program, conducted primarily by nurses, which promotes comprehensive monitoring, bond building, and recognition of family beliefs and practices in childcare[7].

Everyday PHC care is produced at the interface between two systems of knowledge: the scientific, historically supported by biomedical rationality, and the empirical, built by families and communities based on life experiences, beliefs, and cultural traditions. This duality challenges nurses' professional practice, as care extends beyond the technical dimension to encompass symbolic meanings, emotional relationships, and sociocultural values. Thus, professional practice requires skills that go beyond the technical dimension, including qualified listening, cultural sensitivity, and dialogical capacity[8-9].

Health education in Brazil has historically favored a positivist view, which delegitimizes popular knowledge and traditional practices. However, this knowledge is part of the fundamental dimensions of human experience and the health-disease process, influencing care, adherence to guidelines, and trust between families and services. Understanding how nurses navigate this duality is strategic for strengthening comprehensive care in PHC, in line with the principles of the SUS and Popular Education in Health[8-9]. Thus, the research question of this study is, how do PHC nurses understand and integrate popular practices and beliefs in childcare? Therefore, the objective of this study was to understand the role of Primary Health Care nurses in relation to popular practices and beliefs in children's health care.

Methods

Type of study

This is a qualitative study. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guide was adopted for the development of the research report.

Study location

The research was conducted in a border municipality in the state of Rio Grande do Sul, which has 18 Family Health Strategy (FHS) units and three Basic Health Units. For data collection, four FHS units with the highest population coverage and the highest de-

mand for care were intentionally selected, according to the municipal management report, to include professionals with extensive contact with children and families in reception and childcare services. The chosen health units are in urban areas and have the following population coverage: FHS A covers 8,866 people; FHS B covers 8,100 people; FHS C covers 9,302 people; and FHS D covers 5,850 people. The latter two units had two teams in operation.

Data collection period

Data collection took place between April and June 2024 through semi-structured interviews, with an average duration of 30 minutes.

Data collection and instrument

The researchers developed the interview script. The instrument was evaluated for content consistency, theoretical adequacy, and alignment with the study objectives by two specialist nurses. The interviews were conducted by the principal investigator, a nursing academic, who underwent specific training to standardize the approach and ethical conduct of the interviews.

Study population

All nurses from the four FHSs were invited to participate, for a total of 9 participants. The inclusion criteria were nurses working in PHC for at least six months and who performed childcare consultations. The exclusion criteria were nurses on leave or vacation during the data collection period.

The invitation to participate in the study and the interview were conducted in person by the researcher at each selected FHS. The interviews took place in a private room to ensure the participants' privacy. For the semi-structured interview, a predefined research instrument with an open and closed question script was used, which served as support for the researcher[10]. The closed questions addressed participants'

sociodemographic characteristics, and the open questions addressed the research topic. The main trigger questions analyzed in this study were: "Tell me what you understand by popular practices and beliefs?" "How do you acquire knowledge about popular practices and beliefs related to child health?" "What are the team's behaviors regarding the practices and beliefs used by parents/guardians?" "Do you seek to adapt your care approaches based on these practices?" "Do you have any suggestions for improving child health actions that align with popular practices and beliefs?" The interviews were recorded and subsequently transcribed manually in their entirety, ensuring the reliability of the statements. The information was stored in a Google Docs database.

To ensure participants' anonymity, the names of prominent figures in nursing were used. Thus, after agreeing to participate in the study, each interviewee chose the code that best represented her from among the following suggestions: Wanda Horta; Florence Nightingale; Ana Neri; Dorothea Orem; Maria Rosa; Ivone Lara; Olga Verderese; Callista Roy; Mary Seacole; Myra Levine.

Data analysis

Content analysis involves a cursory reading of the interview transcripts to identify initial impressions and organize the material. The second stage, exploration of the material, represented a classification period that sought to achieve the focus of the text by grouping the following core meanings: perceptions and knowledge about popular practices and beliefs; ways of acquiring this knowledge; behaviors in relation to popular practices and beliefs; main barriers in the relationship between nurses and families; and strategies to improve health actions focused on child health. This stage was carried out independently by two researchers, who later met and observed convergence in the thematic nuclei they constructed, with only the nuclei's titles modified. After analyzing these clusters, two thematic categories were built to respond to the

research objectives: Nurses' perceptions of popular practices and beliefs related to child health and Nurses' behaviors in addressing cultural practices in child health: action strategies. The third stage, treatment of the results obtained and interpretation, refers to the moment when the material was interpreted, relating it to the research objectives and the scientific literature[10].

Ethical considerations

To guarantee anonymity and ensure that participants could withdraw at any time, a Free and Informed Consent Form was made available, signed in duplicate, with one copy given to the participant and the other retained by the researcher. The research project was approved by the Research Ethics Committee of the Federal University of Pampa with the Certificate of Ethical Review number 76914924.5.0000.5323 and under opinion no. 6,700,833/2024.

Results

Nine female nurses participated in the study; eight were between 39 and 46 years old, and one was 60 years old. The average length of training in the field was 13.44 years. All participants had a specialization; among the courses taken, Family Health and Urgency and Emergency were the most prevalent, followed by Women's Health/Gynecology, Obstetrics, Hospital Infection Control, Preceptorship in the SUS, Oncology, Auditing, and Gerontology.

Regarding the length of time working in PHC, five nurses have been working for less than 10 years, three for 10-20 years, and one for more than 20 years. According to the participants, the main practices used by families in the territory include the application of teas, coins, and/or bands to the umbilical stump, as well as the use of food products such as cooking oils, honey, cornstarch, sugar, and onions.

1) Nurses' perceptions of popular practices and beliefs related to child health

This category brings together statements that show how nurses recognize, interpret, and attribute meaning to popular practices and beliefs in the context of childcare. The thematic nuclei reveal that such knowledge is culturally constructed, transmitted between generations, and observed in everyday professional practice.

Beliefs, practices, and knowledge from the perspective of nurses

Nurses demonstrated similar perceptions of popular practices and beliefs, characterizing them as knowledge derived from specific local cultures and families. This knowledge comes from empirical experiences built up over years of caregiving. This knowledge is part of a cultural heritage passed down from generation to generation and naturally present in everyday family life: *The practices are related to the family's popular knowledge. Here we see many people with the beliefs of their grandparents and parents about how to care for a person, a loved one, and this is passed down from generation to generation. So, it is more linked to cultural, family, and local issues, because these vary. I have worked in another place, and I saw that in another region the belief was one thing, and here the belief is another* (Mary Seacole)*. It is information passed down from family to family. My mother passed it on, my grandmother passed it on to my mother, who passed it on to my daughter, those guidelines about some care that were not scientific and were not given by a professional, but from the knowledge they had over the years and their practices at home* (Callista Roy)*.

Encountering difference: professional knowledge under construction

The nurses' knowledge of popular practices was acquired mainly through their daily work, contact with families, and contact with other professionals on

the team, which allowed them to identify traditional customs and knowledge. In addition, the participants sought to learn and elevate their knowledge independently, through reading, studying, and exchanging experiences with other professionals in the department: *Through the patients themselves, through reading, they appear, for example, with coins in their navels, with belly bands, with fennel tea. So, we try to understand why they are doing that and, based on that, guide them on how far they can go with that practice or not* (Callista Roy). *Studying, always looking for something that comes up out of my own interest* (Dorothea Orem)*. I can tell you that what I know today, what I am still learning, is from my fellow nurses here at the unit, who already have extensive experience in family health and public health* (Maria Rosa).

For one of the professionals, the first encounter with these customs was strange, as it diverged from the scientific knowledge she had acquired during her undergraduate studies. However, encountering these popular practices contributed to her understanding of the mother's culture and language, which in turn favored health guidance strategies: *It's in everyday life, at work, as we talk, it struck me as very strange when I first started, we rely heavily on science, and then a child arrives with an onion under their armpit or inside their sock, because onions lower the temperature. Or else, I also learned about the Mother of the Body and different signs that the body gives, which have popular names. We learn to understand and talk to guide others* (Ivone Lara).

Academic experiences and the approximation with popular knowledge

One participant's remarks about her exposure to the topic during her undergraduate studies, specifically in Child Health classes, are also noteworthy. On these occasions, the different care practices adopted in the region were discussed: *Many things were covered during college, we talked a lot. Thank God, I had great teachers in child health. So we discussed everything at length. And I also think that this is even more pronounced in rural areas. I already had the things I saw in my family, in my acquaintances, and that we question during our training and understand why they do it that way, why they think that way* (Florence Nightingale).

Learning to welcome training as a strategy for improving work

Participants suggested specific training strategies for the topic. They highlighted the need for all professionals on the FHS team to participate in these actions: *Training, not just for us nurses, but for the whole team, because these guidelines don't just come from me, but from the team of technicians, health agents* (Callista Roy)*. There's the issue of training. I always say that at university we must use and abuse it. I love it when there are students, because students bring something new, and I think that's a very important exchange. We have the experience, and the students have the new. So, I think that training, even to demystify things a little, we can't just invalidate what was done before. We need to understand and think technically, know the theory, and reflect on why it's done* (Florence Nightingale).

2) Nurses' conducts in approaching cultural practices related to child health: action strategies

This category presents the main strategies adopted by nurses in response to the popular beliefs and practices identified among families. The strategies involved communication, bonding, childcare consultations, health education, professional training, and teamwork.

Listening and dialogue: communication as a bridge between knowledge

The nurses noticed that some families were resistant to the guidelines, which proved to be a significant barrier to care. However, by using communication adapted to the family's language, they observed greater openness and receptivity to dialogue: *We have to try to speak the family's language, try to make sure the family understands. It's that thing of making sure they understand* (Ana Neri)*. At first, we see resistance. Usually, this resistance does not come from the mother, but from the grandmother. Usually when they come for a consultation, they are accompanied by their mother or grandmother. But maybe there is resistance because it is more a question of guidance. Because it's not just me saying, you can't, I have to explain why,*

or it's better to do it this way. And make her understand, and in the conversation, in her own words, you will see if she really understands you or not (Callista Roy).

Bonding with families: the foundation of care

Another fundamental aspect is building bonds with families. Bonding represents a strategy for reducing barriers to communication and understanding, contributing to more effective exchanges between professionals and families. This aspect is evident in the care provided to foreigners: *We even have users who are from other countries here, but I haven't seen this problem. When users see that we are committed to really helping them, they begin to have a different view of what we are talking about. So, the barriers are overcome when we have this exchange. I learn from what they bring us, and they also commit to doing what we are asking. And then they tell us, because I always ask them to tell us how the experience was. So we need to have this exchange, mainly because it is a bond. We cannot forget that the first point is the issue of bonding* (Mary Seacole).

From prenatal care to childcare: nursing consultations as a care strategy

Considering popular practices and beliefs about child health, strategies have emerged to improve health care. The suggestions involve practical, individualized guidance that addresses each family's specific needs and values their sociocultural context. The professionals highlighted the importance of prenatal and childcare follow-up consultations, to continue care for the child's development and growth, as well as monitoring family care, valuing their cultural knowledge: *Yes, in the waiting room, give written guidance, bring the mother in during prenatal care, to start with, because they don't take childcare seriously. The importance of appointments, of being there every month, seeing the child's development* (Olga Verderese). *And we observe this closely, observe the child's development, how it is going, how they are caring for the child. I think that's the goal of childcare, in addition to ensuring the child's proper development, we also take care of this cultural aspect. What's happening in that family, what that family is doing for the child. At these appointments, we'll have a better view* (Wanda Horta).

Knowledge in circulation: groups and social media in promoting child health

The nurses also suggest optimizing health education activities through FHS-organized groups and social media. According to them, these tools facilitate the exchange of information and guidance, especially for disease prevention and health promotion: *I believe that groups are always important, these exchanges of ideas. Social media is very strong nowadays, so talking a little about this, the media speaks at a cultural level, I believe that promotion and prevention are cultural and it is very difficult to promote and prevent health, because the general population, I see, does not want to prevent, they prefer to treat. So I think that prevention with groups, I believe, helps a lot* (Dorothea Orem).

Discussion

Health care is part of everyday life for humanity, shaped by the needs encountered in the health-illness process. From this perspective, unique ways of caring are generated, determined by the cultural, geographical, and social relationships of each family, community, and/or human group[11-12].

Embracing cultural practices does not mean denying science, but rather recognizing that care is built on interaction, listening, and negotiation among different types of knowledge, thereby increasing the effectiveness of health actions in the territory. In addition, childcare is influenced by social determinants that shape the practices families develop and cannot be reduced to a strict clinical perspective.

The biomedical model is insufficient for understanding the complexity of childcare because, by emphasizing disease-centered interventions, it ignores the structural dimensions that generate vulnerability, such as access to health care and social and cultural conditions. In contrast, the integrated PHC model, guided by health promotion and equity, recognizes that illness is related to living conditions, valuing dialogical and contextualized interventions that articulate scientific knowledge and popular practices[3,13].

The popular practices and beliefs identified by

nurses in the study highlight the influence of the sociocultural context on childcare, particularly the use of homemade teas and coins or bands placed over the navel. These cultural manifestations need to be understood as historical expressions of care and protection passed down through generations.

In this study, it was possible to identify that professionals recognize the use of these practices and the ways they are constructed and passed down within the family culture. It is known that the birth of a child mobilizes the family; thus, social roles are defined, and members begin to contribute to care[14].

Given this scenario, popular beliefs and family traditions are part of caregiving and promote feelings of trust and affection, full of meaning and symbolism for new caregivers. The approach to these practices requires a welcoming attitude, as it directly affects the relationship between members and the social roles they play within the family unit.

Given this dynamic involving childcare, nurses identified that some members are resistant to professional guidance, especially when it differs from the practices historically carried out by the family. Another study observed that family resistance to guidance can lead to greater adherence to superstitions and directly influence care[7]. It can even delay the search for services, interfering with the timely provision of essential care for children's growth and development[15].

Faced with this reality, health professionals encounter difficulties in providing care, including the family's sense of satisfaction with their customs, the health team's lack of knowledge of this culture, and the divergence between popular and scientific knowledge[14]. Due to this divergence, for professionals, this knowledge often creates confusion, requiring the ability to listen to and understand family culture to develop more effective communication and health guidance strategies[16].

In addition to the above, it is also necessary to consider that health professionals often dismiss popular health practices as superstitions or habits lacking a scientific basis. However, many of these practices are part of a broad system of care historically developed by traditional communities and recognized by the Ministry of Health as integrative and complementary health practices, regulated by the National Policy on Integrative and Complementary Practices[13].

The lack of knowledge of traditional and cultural understandings among professionals may stem from the absence of this content in undergraduate curricula in health fields, thereby weakening training grounded in an integrated health model. Another aspect that deserves critical reflection concerns the risks of nursing training in the distance-learning modality in Brazil, due to the weakening of the teaching-service link and the loss of the human-social dimension of care. Health training requires field experience, interaction with users and teams, and care experiences that develop ethical, relational, and clinical skills for work in PHC, which cannot be mediated by virtual environments[17].

Most professionals reported that contact with the subject occurred in their daily work, suggesting the need for training to expand their knowledge of popular knowledge and customs. The term training reveals a vertical pedagogical concept, centered on the transmission of content and the correction of individual gaps, and on specific, decontextualized training, which distances itself from the principles of PNEPS. Unlike the training approach, Continuing Education proposes critical and reflective training, based on the problematization of practice and meaningful learning from the daily routine of services, in dialogue with the subjects of the territory. Inspired by Paulo Freire's thinking, PNEPS advocates a liberating pedagogy that recognizes workers and users as protagonists in the production of knowledge, thereby overcoming banking and instructional models of teaching. Thus, discussing cultural practices in PHC requires dialogical and horizontalized educational processes that offer opportunities to transform and qualify care[18].

In nurses' work in child health care, communication and bonding are key care strategies. Communication, in its various forms, can be hampered by language barriers, sociocultural differences, and

differences in cognitive and intellectual development among social actors, limiting understanding[19-20]. Professionals recognize the need to overcome these obstacles by using strategies such as adapting language to the realities of families, avoiding technical terms, and prioritizing detailed, accessible guidance, which promotes understanding and reduces resistance to guidance[16].

Such strategies facilitate the establishment of a therapeutic bond as a tool that promotes understanding of the individuality and living conditions of families. In addition, it is a relationship of acceptance, humanization, and comprehensiveness, sustained by respect, trust, and listening[21-22]. For the participants, this bond facilitates exchanges with the family and reduces communication barriers.

To improve health actions, the participants also suggest continuity of care through follow-up at prenatal and childcare appointments. Childcare plays a vital role in preventing health problems in children and strengthening childcare[20]. In the context of this study, childcare is also seen as an ideal opportunity to build closer ties with the family and to understand popular childcare practices. This follow-up allows professionals to gain a broader understanding of the family and cultural context in which the child is developing, as well as to identify risk situations early, negotiate practices with the family when they are not beneficial to the child's health, and provide health guidance[23-24].

Although the literature predominantly describes childcare as a strategy for monitoring child growth and development[16], the results indicate that nurses have redefined this space as a moment for dialogue, listening, and cultural mediation. This practice is like Freirean pedagogy and PNEPS-SUS, as it values popular knowledge and promotes shared care. Thus, childcare is not only a clinical tool but also a culturally sensitive care strategy capable of integrating knowledge and strengthening therapeutic alliances.

It is known that continuous follow-up in childcare presents barriers in Brazil and other countries[7,25]. In Ecuador, many caregivers seek health services only when children become ill, rather than as a preventive measure or for guidance on children's health and development. A prevalent trend in rural areas of the country is the preference for traditional medicine. As strategies, he highlighted health education interventions and the importance of home visits to observe the interaction between the caregiver and the child, aiming for effective, personalized care[26].

The present study also highlighted the importance of involving the academic community in PHC, expanding learning opportunities for teams and future professionals. The integration of teaching, service, and community supports professional development, enabling quality care for the community. In addition, this relationship can create opportunities for reflection on the cultural and social diversity of service users, fostering ongoing transformation in health care[27].

The testimonials point to the use of group strategies in the FHS and on social media to exchange information about popular beliefs and practices in childcare, expanding spaces for guidance and clarifying myths. Social media, although powerful for health education, also favors the dissemination of fake news, generating misinformation and insecurity in families. Thus, health teams must promote digital literacy in health, strengthening families' critical capacity to evaluate information and make safe decisions about childcare[28].

Group approaches in the FHS favor exchanges and the possibility of more horizontal care, overcoming the vertical logic that sometimes characterizes consultations. Therefore, group strategies are recommended in services, as they strengthen participatory care and family autonomy and can involve caregivers, community leaders, and teams[15,29].

The training of Community Health Agents (CHAs) should include skills in intercultural communication and mediation of popular knowledge, since these professionals are strategic actors in the territory. Their presence in the community and understanding of local realities make them mediators between

different rationalities of care, articulating technical--scientific knowledge with local popular practices. In addition to facilitating access and strengthening bonds, CHAs also perform pedagogical functions in health education, enhancing families' autonomy in self-care[30]. Thus, the valorization and qualification of agents are essential to advancing the construction of a culturally sensitive and socially committed care model in tune with the realities of the territories.

Therefore, the findings of this study highlight practical implications for PHC care, such as developing protocols to support team organization, risk assessment, and the negotiation of popular practices without breaking ties. It is also essential to include such issues as cultural competence and intercultural communication in professional training, and to strengthen interdisciplinary strategies, valuing the role of CHAs and the multidisciplinary team in the construction of shared plans. Such actions qualify for nursing work, strengthen integrality, and expand the effectiveness of PHC.

Study limitations

One limitation is the narrow focus on PHC nurses' perspectives, limiting the diversity of knowledge and experiences. The small number of participants may also restrict the range of perceptions and the generalizability of results to other contexts. In addition, there may be social desirability bias in the statements, since some responses may have been influenced by the desire to present behaviors considered appropriate, despite methodological precautions to ensure confidentiality and anonymity.

Contributions to practice

Including this topic in undergraduate and continuing education helps train professionals who are more sensitive and committed to humanized practices. In addition, strengthening culturally sensitive care in PHC requires recognizing integratory and complementary health practices as legitimate resources of the SUS

and valorizing participatory strategies led by community leaders, such as healers, midwives, herbalists, and popular caregivers. Such practices promote interculturality, social protagonism, and comprehensive care, respecting the diversity of knowledge in the territories.

Conclusion

The study indicated that popular practices and beliefs are integrated into childcare in Primary Health Care, and that nurses recognize and manage them through dialogue, language adaptation, and bonding with families. Childcare consultations stand out as a space for negotiating cultural knowledge, expanding the role of nursing in mediating between scientific and popular knowledge, and strengthening culturally sensitive care in everyday healthcare.

Authors' contributions

Conception and design: **Andrade EO, Santos EO, Cruz VD, Sigaran LA**. Data analysis and interpretation; Writing of the manuscript or critical review of the intellectual content; Final approval of the version to be published; Agreement to be responsible for all aspects of the manuscript related to accuracy or integrity being investigated and resolved appropriately: **Andrade EO, Santos EO, Cruz VD, Sigaran LA, Prates LA**.

Data availability

The authors declare that the entire dataset is available only in the body of the article.

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