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Original Article

SOCIAL REPRESENTATIONS OF POSTPARTUM WOMEN ON PRENATAL CARE IN PRIMARY HEALTH CARE

REPRESENTAÇÕES SOCIAIS DE PUÉRPERAS SOBRE O ATENDIMENTO PRÉ-NATAL NA ATENÇÃO PRIMÁRIA DE SAÚDE

REPRESENTACIONES SOCIALES DE PUÉRPERAS ACERCA DEL CUIDADO PRENATAL EN LA ATENCIÓN PRIMARIA DE SALUD

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This article aimed at capturing the social representations of postpartum women on prenatal care in primary health care. This is a descriptive, qualitative study, guided by the Theory of Social Representations, developed in nine Family Health Centers, in Fortaleza, Ceará, Brazil, from May to July, 2012. 31 women on postpartum were interviewed through semi-structured interviews. The interviews were recorded, fully transcribed and processed through ALCESTE software - 2010 version. The results observed in the lexical analysis of the interviews revealed the distribution of contents in four classes. Classes 4 and 1 dealing with prenatal care were explored in this study. Social representations of users about the prenatal are anchored in the protocol dimension and socio-educational dimension. The implantation and the maintenance of activities are necessary in order to share knowledge and interaction among the users.
Descriptors: Prenatal Care; Pregnancy; Pregnancy; Psychology Social.

Objetivou-se apreender as representações sociais de puérperas sobre o atendimento pré-natal na atenção primária de saúde. Estudo descritivo, qualitativo, norteado pela Teoria das Representações Sociais, desenvolvido em nove Centros de Saúde da Família, em Fortaleza, Ceará, Brasil, de maio a julho de 2012. Participaram 31 puérperas, por meio de entrevista semiestruturada. Estas foram gravadas, transcritas na íntegra e processadas através do *software* ALCESTE - versão 2010. Os resultados observados na análise lexical das entrevistas revelaram a distribuição dos conteúdos em quatro classes. Exploraram-se neste estudo as classes 4 e 1, que tratam do atendimento no pré-natal. As representações sociais das usuárias sobre o pré-natal estão ancoradas na dimensão protocolar e na dimensão socioeducativa. Faz-se necessária a implantação e a manutenção de atividades para o compartilhamento de saberes e de interação entre as usuárias.
Descritores: Cuidado Pré-Natal; Gestação; Psicologia Social.

El objetivo fue identificar las representaciones sociales de puérperas acerca del cuidado prenatal en la atención primaria de salud. Estudio descriptivo, cualitativo, guiado por la Teoría de las Representaciones Sociales, desarrollado en nueve Centros de Salud de la Familia, en Fortaleza, Ceará, Brasil, de mayo a julio de 2012. Participaron 31 mujeres después del parto a través de entrevistas semiestructuradas. Estas fueron grabadas, transcritas íntegramente y procesadas por el *software* ALCESTE - versión 2010. Los resultados observados en el análisis léxico de las entrevistas revelaron la distribución de contenidos en cuatro clases. Explorado en este estudio las clases 4 y 1, que tratan de la atención prenatal. Representaciones sociales de los usuarios sobre el prenatal están ancladas en la dimensión de protocolo y socio-educativa. Es necesaria implementación y mantenimiento de actividades para el intercambio de conocimientos y la interacción entre las usuarias.
Descriptores: Atención Prenatal; Gestación; Psicología Social.

*Excerpt from the paper "Representações sociais de puérperas sobre a educação em saúde no ciclo gravídico-puerperal", Programa de Pós-Graduação Cuidados Clínicos em Enfermagem e Saúde, Universidade Estadual do Ceará, Brazil, 2012.

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INTRODUCTION

Pregnancy can be considered a singular phenomenon in the life of many women, characterized by constant modifications and physical, hormonal, psychological, emotional and social alterations[1]. Facing that, there is the need of a specific care to each during pregnancy, once it is a period of transformation, permeated by doubts and aspirations.

Regarding the care offered by the health professionals in the period of the pregnancy, the prenatal period is the supervision of the evolution of the pregnancy which aims at taking care of the health of the woman and her baby until the birth happens. That includes the prevention of diseases the promotion of health, as well as the diagnosis and the treatment of the problems which might occur during this period[2].

Therefore, the adhesion of the women to the prenatal care is related to the quality of assistance rendered by the service and by the health professionals, and is an essential factor for the reduction of the high rates of perinatal and maternal mortality[3]. However, other aspects are also determinant in the adhesion to prenatal care such as: access to the service, humanization, net of services for complete assistance, previous experience, recognition of the importance and benefits, among others.

Visualizing the ways to reach the objectives of prenatal assistance, the Health Department released the Programa de Humanização no Pré-Natal e Nascimento (Program of Humanization in Prenatal Care and Birth) (PHPB), in 2009, which has as main strategy to assure the improvement of the access to the covering and quality of prenatal care supervision, to the assistance to the delivery and of the puerperium of the women and to the newborn, in the perspective of the rights of the citizenship[4:5].

As a way to provide continuity to the focus on humanization in maternal and child care, the Health Department created the Programa Rede Cegonha (Stork Net Program) in June 2011, whose goal is to guarantee an assistance of quality to all Brazilian women through the Sistema Único de Saúde (SUS) (Unified Health System), from the confirmation of the pregnancy to the first two years of the baby's life. According to the general and operational guidelines of this program the women must have the right to a reproduction planning and to humanized attention throughout the pregnancy, the delivery and the postpartum; the right to a safe birth, growth and healthy development must be assured to the children[5].

The proposals developed by the Health Department, including the PHPB and the Stork Net Program, reveal that the assistance to the woman in the pregnant-puerperal period and to the newborn must be provided completely and in a humanized way, attending the main needs presented by the woman during pregnancy, delivery and puerperium[4-5].

The assistance in the prenatal care in primary attention involves the users with outstanding roles, allowing inferring the existence of representations in this group. The way of expression of the women on this topic provides directioning regarding how their supervision has been conducted during pregnancy by the health professionals of the services of primary attention to health.

Under this perspective, the assistant in prenatal care is understood under the social look of the meanings, considering the users as bearers of elaborated knowledge and socially shared by the interaction[6]. This assistance emerges as object of relevance to the group of women who experienced the phenomenon of pregnancy, which can rouse Representações Sociais (Social Representations) (SR), which guide the users in the actions on reality, having as basis a system of values defined under the social influence.

Accessing the SR of the puerperas on the assistance in prenatal care implies in understanding their

interpretations and feelings on this matter, under the focus on the knowledge elaborated in the daily lives of the social groups – the knowledge of the common sense[7]. The representations provide sense, orientate and guide the social groups. They form practical knowledge both for being inserted in the experience, which involves a historical, cultural and special context, and also for orientating the communication and behavior of the subjects[6].

Therefore, the study aimed at apprehending the social representations of the puerperas on the prenatal care assistance in primary attention of health.

METHOD

This study was guided by the Theory of the Social Representations (TSR), developed in nine Family Health Centers (FHC) of the Secretaria Executiva Regional (SER) IV (Regional Executive Department), in the county of Fortaleza, Ceará, Brazil. 31 users participated, the ones who complied with the criteria of inclusion: puerperas registered in one of the FHC of the SER IV, above 18 years, who had at least six prenatal appointments and one puerperal appointment. It is noticed that the sample was chosen following an intentional criterion until the occurrence of the theoretical saturation of the data which occurred with 31 interviews.

The semi structured interview was chosen as data collection technique, once it is an instrument which provides the interviewed woman with the possibility to discuss the topic being questioned without being linked to the question elaborated by the researcher[8]. The instrument contemplated the obstetric and socio familiar demographic profile of the participant and explores the senses attributed to the prenatal.

The interviews were made after the acceptance of the participant and the signature of the Informed Consent Form. They were held at FHC or in the homes of the users, privileging the privacy and availability of the participants. The interviews were recorded, and totally transcript and only one data bank was prepared to be processed through the ALCESTE *software* (Contextual Lexical Analysis of a Set of Segments of Text) - version 2010.

The data processing program ALCESTE uses an analysis of Classificação Hierárquica Descendente (Descendent Hierarchical Classification (DHC) and provides a lexical analysis of the text offering contexts (lexical classes) which are characterized by their vocabulary and by the segments of texts which share this vocabulary[9].

The *corpus* of analysis is formed by the units of initial context (uic), units from which the program will make the initial fragmentation and which correspond to each interview made. In a standard analysis, after the program recognized the indications of the uic, it divides the material into units of elementary context (uec), units with the minor fragment of sense. The chi-square (khi2) calculates the frequency of the word shown and it indicates the degree of statistic association of a word or variable to the class. The higher the khi2 is, the more relevant the word is for the contribution of the class[9]. The analysis of the khi2 indicates the topics around which the discourse is articulated under the light of semantic context of the words of greater statistic association to the class and also shows the researcher the role of the variables in the organization of such classes.

Thus the program provides the number of classes resulting from the analysis, as well as the reduced forms, the semantic context and uec characteristics of each consolidated class. Once they had this material, the authors made the context of the same explicit, naming each class from all the information supplied by the *software*. At last, the interpretation and analysis of the classes were fundamented in the processual perspective of the TSR. The statements of the participants are numbered by the uec, khi2 and uic.

The entrance in the place of investigation was possible after the approval of the project by the Committee of Ethics in Research of the Universidade Estadual do Ceará, Brazil, with Legal Opinion no. 26905 and CAAE 01261912.5.0000.5534. After the authorization of the study by SER IV and the approval in the committee, the data collection occurred from May to July, 2012.

RESULTS

Regarding the obstetric and socio-familiar-demographic profile of the 31 participant women, it is possible to state that they were, in their majority, multiparas (64.5%), in the age range from 18 to 33 years (71.0%), they lived with a partner (64.5%), studied until grade school (48.4%), had remunerated jobs (87.1%), they gave birth through cesarean (71.0%) and did not suffer intercurrences in the pregnancy-puerperal (71.0%).

From the data processing in the ALCESTE *software,* 1,913 distinct forms or different works were found. The program was 75% useful. When 75% or more of the uec were classified, the DHC it was considered to have good performance. 368 uec were selected, from which 275 were classified into four classes. Each class is made up by groups of several uec of homogenous vocabulary.

It is worth clarifying that for the purposes of this article the contents present in Class 4 were explored and discussed: evaluation of the assistance in the prenatal period and in Class 1: prenatal: the health professionals and the procedures, once the lexics which explore the object chosen for discussion are concentrated in those classes. Because they have higher statistic significance in terms of aggregation of uec, reaching 28% of the total, Class 4 was described before Class 1 (10% of the total). Both discussed in the topic Assistance in the prenatal.

Class 4: the evaluation of assistance in the prenatal

It is formed by 78 uec and 53 analyzable words. The illustrative vocabulary of this class is: doubt (khi2 = 27), cleared (khi2 = 14), fine (khi2 = 14), asked (khi2 = 14), prenatal (khi2 = 13), pain (khi2 = 12), normal (khi2 = 11), salt (khi2 = 8), risk (khi2 = 8), pregnancy (khi2 = 7), assisted (khi2 = 7), exam (khi2 = 5), cesarean (khi2 = 5), talked (khi2 = 5), supervision (khi2 = 5).

These words represent the assistance in prenatal care: protocol, with the making of exams, as it is also characterized by the orientation, in the scope of individual educational actions. The group of women evaluated the assistance of the health professionals from the representation which presented value judgment referring to the quality of the assistance received: *She (the nurse) examined me, asked me how I was, what I felt, if the baby was moving or not, she asked me everything related to him and to me* (uec no.334; Khi2 = 14; uic no.27). *It was fine, wonderful. When I came into the room, Yes, the doctors were wonderful. Well assisted* (uec no.164; Khi2 = 11; uic no.11). The statements evaluated the care provided during pregnancy positively.

In this study, the women considered the exams fundamental to a good supervision. They reported assistance from the promptness of the making of exams and the supervision of the health professionals along the experienced period*: So, I was very anemic and he couldn´t find out what is was. He made exams and exams and he didn´t find out what it was* (uec no.21; Khi2 = 12; uic no.2). *Then she placed you in a waiting line for you to have a breast ultrasound, a transvaginal exam and this takes too long, and many women do not come to the health post because of that* (uec no.88; Khi2 = 6; uic no.6).

Besides asking for the exams, the assistance of the health professionals show as focus the educational orientations: *Because actually you need help, the more children you have, the more health you need. The more orientation, the more you go. Always, they were always welcome to me, whatever they tell me is valid. When I was pregnant and had prenatal care, the nurse always helped me* (uec no.231; Khi2 = 9; uic no.15). *For me not to eat too much pasta, to eat more fruit, to take a lot of liquid. Regarding the delivery, she (the nurse) orientated that when pain comes every five minutes, it meant it was time for delivery* (uec no.239; Khi2 = 9; uic

no.16). *I knew it was, but it was hard, because I didn´t want to have children anymore. I was not prepared. I always asked the doctor, because my pregnancy, that he always thought was risky due to my weight, but he told me that the way I was behaving was fine, that I should go on* (uec no.160; Khi2 = 7; uic no.11). *The doctor who assisted me during the prenatal, if I had any doubts he would clear* (uec no.16; Khi2 = 6; uic no.1).

It was also noticed that some women did not feel at ease to clear their doubts with the health professionals choosing to look for the orientation provided by their friend´s boss or still looking for information in the media, in magazines and on the internet: *It was nice and now I have the baby. But it was good, in my pregnancy I was well assisted, it was nice. I always cleared my doubts with my boss. I was in doubt about my pregnancy, because I didn't want to have more children, but she was the who supported me a lot, gave me strength to have this baby, who was real nice* (uec no.159; Khi2 = 11; uic no.11). *No, we didn't talk a lot, no, I didn´t talk much, I am very reserved. I kept listening, but I didn´t ask, no. I cleared my doubts with my friends. They would only say that in the pregnancy, when time came, I was going to suffer a lot* (uec no.240; Khi2 = 8; uic no.16). *Received. No, no, it was only conversation with the doctor. Now we see it a lot on tv and read in the magazine because when we are pregnant we become interested in reading in the magazine and we end up seeing it on the internet too, but with the doctor it was only the exams* (uec no.5; Khi2 = 6; uic no.1).

Class 4 presented statistic association with the woman that live with their partners (Khi2 = 13), in the age range between 34-41 years (Khi2 = 6) and multiparas (Khi2 = 4). The typical subject of the class the interviewed woman 11(Khi2 = 19). It was also noticed that the multiparas and older woman talked more about the evaluation of the assistance, for their maturity and their experience with the health professional´s supervision.

Class 1: prenatal care, the health professionals and the procedures

This class is formed by 27 uec and 36 analyzable words. Is the class with smallest statistic significance in terms of aggregation of uec, reaching 10% of the total. The illustrative words of this class are: belly (khi2 = 66), received (khi2 = 47), medication (khi2 = 40), heart (khi2 = 37), listen (khi2 = 31), ultrasound (khi2 = 28), baby I (khi2 = 18), baby II (khi2 = 11), condom (khi2 = 11), result (khi2 = 11), orientations (khi2 = 11), weigh (khi2 = 9), female doctor (khi2 = 9), male physician (khi2 = 8), visit (khi2 = 7), talked (khi2 = 7), appointment (khi2 = 6), take (khi2 = 5).

These words represent the routine procedures performed during the assistance in prenatal care, focusing on the baby, besides analyzing the health professionals and their work: when offering educational orientation in the appointments, measuring the uterus height, listening to the fetal heart beat, asking for ultrasound exams prescribing medicine and checking the weight. *Received; we get there, she asks to be weighed, checks blood pressure, listens to the baby´s little heart, measures the belly to see if it is ok, that´s it* (uec no.363; Khi2 = 29; uic no.31). *The doctor (physician) lay me down and used a little machine to listen to the baby, measured my belly, it was ok.* (uec no.142; Khi2 = 18; uic no.9). *Regular appointment. He (the physician) measures the belly, listens to the baby´s heart, applies ferrous sulfate and that´s it. Because the doctor (the female physician) I went to see her only once, because she was never here, and then she told how to breastfeed, if the nipple was good for the baby to feed or not* (uec no.106; Khi2 = 14; uic no.7). *Depending on the results of the exams, for example, the diabetes, to see if I had diabetes she asked for the glycemic curve, depending on the result of the curve she asked for a diet, which in my case it was not necessary because everything was alright* (uec no.6; Khi2 = 9; uic no.1). The predominance of a procedure protocol practice was observed.

The need for the pregnant woman to go to private clinics to receive the prompt result of the examination, was reported as follows: *In the prenatal I would go to the ultrasound more often, because when I went there the device to listen was missing, then the doctor prescribed the medicine, those pills we take, ferrous sulfate and another* (uec no.150; Khi2 = 26; uic no.10). *Within fifteen days I already had the results of everything, I went back to the doctor and in one month I had the result of everything and in a public clinic no. Private. It was through the health plan and I did everything, every time I went there, had an appointment with him and had the ultrasound exam at the same time* (uec no.90; Khi2 = 8; uic no.6).

This class presented a statistically significative association by the interviewed woman no. 18 (Khi2 =

11), 05 (Khi2 = 9), 22 (Khi2 = 7) and 19 (Khi2 = 6). These subjects were typical of the class and presented the following characteristics in common: multiparas, had cesarean delivery and had no intercurrences during the pregnant-puerperal cycle.

The attention to the child is the main concern to this group of women: *this is what I understand as education since I was a little girl. The first appointment to feel the baby´s heartbeat, the first appointment when you have the ultrasound exam to know how he is, this is what is the most, the first appointments are the most important, because a fetus is being formed inside your belly* (uec no.253; Khi2 = 14; uic no.18). *It is very important too, it is very important. The first appointment the doctor tells you not to take a 'moon bath' (chloride water to exfoliate the skin and lighten body hair) because it reaches the fetus when is it being formed. . You cannot carry wait because the baby´s brain is being formed. So, these are the orientations which they pass on to us and I think they are very important.* (uec n°254; Khi2 = 28; uic no.18).

The previous statements express assistance anchored in the socio-educational dimension. The woman report great value to prenatal care, partly associated to the existence of another being in their womb, and such reports can be objective in the expression "a fetus is being formed inside your belly". The word important has a positive repercussion in the attention rendered, adding to it the characteristic of value, meaning and sense, as well as the word good: *Ah, it was good. Orientation. The doctor, the nurse orientated me on how I had to do (uec* no.*301; Khi2 = 18; uic* no.*24). I went there. There was. It was the nurse and the doctor. In the appointments. (uec* no.*341; Khi2 = 11; uic* no.*28).*

The dialog and the interaction between the health professional and the pregnant woman have great importance for the adhesion to the appointments: *Received. She passed me everything; she talked with my daughter in my belly, the doctor. I like it very much, because she talked, she caressed. I felt good, it was very good. It was the nurse. It was, but it's because I like the nurse so much that I preferred just with the nurse (uec n°183; Khi2 = 9; uic* no.*12). In the appointments I went to, I always tried to receive orientation. When I go the gynecologist, he always talks, tells me to be careful, always to take the medicine correctly, to use condom and all (uec* no.*260; Khi2 = 45; uic* no.*19).*

The representative contents on the prenatal care assistance attributed by the women are presented in Figure 1, anchored in two dimensions: the protocol dimension and socio-educational dimension.

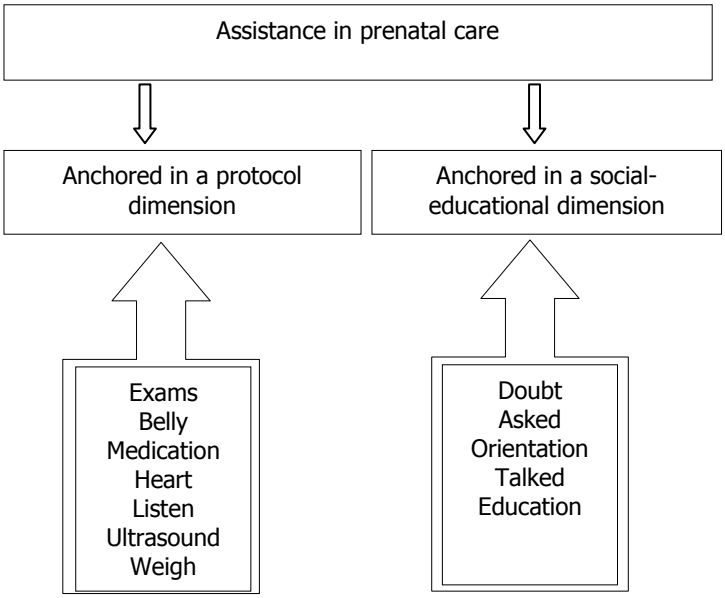

Figure 1 - Social representation of women on the assistance in prenatal care. Fortaleza, CE, Brazil, 2013

DISCUSSION

Regarding the obstetric data in this study, the quantity of cesarean deliveries in the public services of health is alarming, once most of the women did not suffer any intercurrence during the pregnant-puerperal cycle. The data here presented confirm the growth of cesareans in Brazil and its growing ascension. In 2010, the national rate of cesareans reached 52% well above what the World Health Organization preconizes (10-15%)[10].

The Health Department considers as prenatal care of quality the one with early beginning, periodical, complete and with a wide covering[2]. The beginning of the supervision in the first trimester of pregnancy allows the opportune taking of preventive actions, of earlier diagnosis and actions of health promotion. Besides that, it makes the identification possible in the opportune moment of situation of high risk that involves sending the patients to other care centers thus allowing a better planning of the care[2-3].

Class 4 shows how the puerperas evaluate the prenatal assistance in health primary care. It is understood that the quality of the services of care to the woman cannot be effective without considering their needs and/or expectations and without having sensibility and intuition to capture what is necessary to include in the planning of care, so that the user can feel calm and comforted. If any element of the care provided is neglectful, he must be left out to make such care more significative to the woman[11].

The interviewed women evaluate the quality of the prenatal care mainly from the exams made. In another study made in São Paulo, the satisfaction of the user with the services provide in prenatal care has been evaluated from: knowledge of the program of prenatal care, adequacy of the assistance rendered, knowledge of the health team who renders the assistance, knowledge of the hospital which will be the reference for the delivery and the monthly visits of the communitarian agents of health[12].

It is understood that the prenatal assistance of quality is made through a continuous effort of everyone involved in the process, with all the existing means in the community and working environment to make the actions easy and to improve the satisfaction of the users, through a fast, effective, complete and equal assistance[11].

The importance of individual orientation was also reported, although some women did not feel comfortable to clear the doubts with the health professionals. Among the orientation received the focus was the care with the baby.

Other subjects in the literature are evident, regarding the contents of the orientation received from the health professionals which led the appointments of prenatal care, the discussions were on: feeding, physical activity, stress, medication, sexual activity and weight control[13]. This orientation complies with the recommendations of the Prenatal and Puerperium Technical Manual: qualified and humanized attention[14].

The clearing of doubts and the interchange of information between the pregnant woman and the health professional are necessary for the comprehension of the pregnancy process, for the satisfaction of the mother and the family and, consequently, for a positive evaluation regarding the quality of the care received[14-15].

But the women ended up looking for information from other sources such as the family, friends, television and magazines.

Therefore, it is believed that the formation of the link is crucial for a bigger involvement of the pregnant woman in questions related to her health, the attribution of the autonomy and definition of her choices, and consequently, a more conscious perception of the self care[16].

It is highlighted that the link between the health professional and the pregnant woman provides a wider adhesion to the prenatal appointments and guarantees a closer contact of the users with the information on pregnancy, delivery and puerperium, thus contributing to an exchange of different experiences between the women and the health professionals[17].

Socio-economic and emotional elements must be considered in the assistance to the woman and she must be instructed as to the necessary care to have success in this stage. The health professional must offer psychological support to the patient, stimulating the health professional-family link through open dialogs, home visits and group meetings[11].

When analyzing class 1 and the procedures made during the prenatal appointment, having as parameter the technical guidelines of PHPB, there is a higher frequency of the gauging of blood pressure, of the maternal weight and of the measure of the uterine height[18]. These procedures are related by the puerperas in the study.

Other studies have shown the presence of some procedures during the obstetric physical exam of the pregnant woman, such as: the measure of the weight and the height of the woman, the gauging of blood pressure, the auscultation of the fetal heartbeat, the measure of the uterine height and digital vaginal exam. Besides that, the obstetric ecographia was also asked[13].

In order to have adequate prenatal assistance it is necessary to have updated technical scientific knowledge, human resources and/or adequate infrastructure, for example, and adequate physical area, available equipment for the woman´s exam and her baby's, basic medicine sufficient to the demand, trained and able health professionals[11].

As to the exams asked, many puerperas end up choosing private clinics in order not have a delay of the results. A fact also present in another study made at SER IV, in which the results of the exams delayed up to three months to go the pregnant women; therefore they were outdated. The lack of material and technological resources at the FHC was observed[11]. The main problem is the late detection of some complication, which could have been under treatment earlier if there were agility in the results of the exams.

The puerperas anchored the topic 'Assistance in prenatal care´in two dimensions (Figure 1): the protocol dimension, represented by the words exam, belly, medication, heart, listen, ultrasound and weigh and, in the social educational dimension represented by the words doubt, asked, orientation, talked and education.

FINAL CONSIDERATIONS

In the present study, the puerperas reported the assistance in prenatal care as protocol, making routine exams and transmitting the information in the scope of the educational actions. The procedures were made during the assistance in prenatal care, focusing on the baby; they are linked to the orientation in the appointments, measure of uterine height, auscultation of the fetal heartbeat, ultrasound, prescription of medicine and weighing.

It is necessary to have the persistence of the health professionals, so that the activities can be implemented aiming at the improvement of the educational actions in the area of health of the woman, such as the creation and maintenance of groups of pregnant woman, of couples, among other activities, in order to share knowledge and interaction among the users, generating efforts for the educational practice as a way to improve the impact of this action in the physical, mental and emotional health of the woman.

As limitations of this study there was the restriction of a certain SER (IV) in the capital of the state of the Ceará to the FHC, and it must be widened to others and counties in the countryside of the state.

The results found provide support for the adoption of new strategies and technology of assistance in health by part of the health professionals for the supervision of the women during pregnancy, thus allowing the sensitization for change and innovation of attitudes.

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COLLABORATIONS

Guerreiro EM and Rodrigues DP contributed for the conception, analysis, interpretation of the data, writing of the article and final approval of the version to be published. Queiroz ABA and Ferreira MA contributed for the analysis, interpretation of the data, writing of the article and final approval of the version to be published. Rodrigues IR and Melo LPT contributed for the analysis of the data, writing of the article and final approval of the version to be published.

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