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Original Article

PERCEPTION OF PEOPLE IN HEMODIALYSIS ABOUT RELIGIOSITY AND SPIRITUALITY IN THE COURSE OF DISEASE AND TREATMENT

PERCEPÇÃO DE PESSOAS EM HEMODIÁLISE SOBRE RELIGIOSIDADE E ESPIRITUALIDADE NO PERCURSO DA DOENÇA E TRATAMENTO

PERCEPCIÓN DE PERSONAS EN HEMODIÁLISIS SOBRE RELIGIOSIDAD Y ESPIRITUALIDAD EN EL CURSO DE LA ENFERMEDAD Y TRATAMIENTO

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Objective: to analyze the perception of patients who undergo hemodialysis about religiosity and spirituality in the course of chronic kidney disease and hemodialytic treatment. Method: descriptive study, qualitative, conducted with 13 people in hemodialysis treatment. The data collection was carried out in January 2022, by means of an interview, using a semi-structured instrument. For data analysis, the technique of the Collective Subject Discourse was used. Results: three categories emerged: Social support – family, friends and church; Spiritual support – faith, God and prayer; Spirituality – coping and acceptance of diagnosis and treatment. Final considerations: the study highlighted the importance of social support, spirituality and religious practice in coping with chronic renal failure, showing that family and faith help in the acceptance of diagnosis and treatment, and improve the quality of life of patients.

Descriptors: Religion. Nursing. Spirituality. Renal Insufficiency, Chronic. Renal Dialysis.

Objetivo: analisar a percepção dos pacientes que realizam hemodiálise sobre religiosidade e espiritualidade no percurso da doença renal crônica e do tratamento hemodialítico. Método: estudo descritivo, de natureza qualitativa, realizado com 13 pessoas em tratamento hemodialítico. A coleta de dados foi realizada no mês de janeiro de 2022,

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por meio de entrevista, mediante um instrumento semiestruturado. Para a análise dos dados utilizou-se a técnica do Discurso do Sujeito Coletivo. Resultados: emergiram três categorias: Apoio social – família, amigos e igreja; Apoio espiritual – fé, Deus e oração; Espiritualidade – enfrentamento e aceitação do diagnóstico e tratamento. Considerações finais: o estudo destacou a importância do apoio social, espiritualidade e prática religiosa no enfrentamento da insuficiência renal crônica, evidenciando que a família e a fé ajudam na aceitação do diagnóstico e tratamento, além de melhorar a qualidade de vida dos pacientes.

Descritores: Religião. Enfermagem. Espiritualidade. Insuficiência Renal Crônica. Diálise Renal.

Objetivo: analizar la percepción de los pacientes que realizan hemodiálisis sobre religiosidad y espiritualidad en el curso de la enfermedad renal crónica y del tratamiento hemodialítico. Método: estudio descriptivo, de naturaleza cualitativa, realizado con 13 personas en tratamiento hemodialítico. La recogida de datos se realizó en el mes de enero de 2022, por medio de entrevista, mediante un instrumento semiestructurado. Para el análisis de los datos se utilizó la técnica del Discurso del Sujeto Colectivo. Resultados: emergieron tres categorías: Apoyo social – familia, amigos e iglesia; Apoyo espiritual – fe, Dios y oración; Espiritualidad – afrontamiento y aceptación del diagnóstico y tratamiento. Consideraciones finales: el estudio destacó la importancia del apoyo social, la espiritualidad y la práctica religiosa en el enfrentamiento de la insuficiencia renal crónica, evidenciando que la familia y la fe ayudan en la aceptación del diagnóstico y tratamiento, además de mejorar la calidad de vida de los pacientes.

Descriptores: Religión. Enfermería. Espiritualidad. Insuficiencia Renal Crónica. Diálisis Renal.

Introduction

Chronic kidney disease (CKD) is a serious public health problem, considered a high economic and social impact pathology, which can generate complications and mortality, as well as changes that negatively affect the quality of life (QoL) of patients and their families[1-2]. According to the 2022 Brazilian Dialysis Census, the total estimated number of patients on dialysis in July 2022 was 15,383, 3.7% higher than in July 2021, confirming the trend of increasing the number of patients on dialysis observed in recent years[3].

One of the most common modalities of treatment for CKD is hemodialysis (HD), a method of renal replacement therapy in which blood is filtered through a semipermeable membrane[4].

Hemodialysis treatment can be a painful and difficult event, although essential in the life of patients with CKD. The recommendation of the multiprofessional team that attends them is that they need to change their habits and adapt their routines to the treatment and disease, and most often when this change happens, the biopsychosocial and spiritual spheres are also affected and need to undergo changes[5-6].

In this context, spirituality is a complex and multidimensional part of the human experience, based on each person's inherent search for meaning, having to do with reflection and personal search about the meaning of life with regard to the sacred, that may or may not be linked to religion[7]. Religion is an organized system of beliefs, practices, rituals and symbols that facilitate man's closeness to the sacred. It is possible to say that since ancient times religion and health are interconnected[8].

Religiosity, in turn, is based on the acceptance of a certain set of doctrines and values, being even suggested as institutional, systematic and restrictive and can be used as a coping strategy when there are problems that are beyond the ability of individuals or groups to solve[9]. Personal beliefs give meaning to life's suffering situations, for example, chronic disease (CD) is mentioned as both a spiritual encounter and a physical and emotional experience[5].

Coping strategies based on religiosity include the use of religion, spirituality or faith to deal with stress and negative consequences generated by experiences of life's problems[7]. Religiosity and spirituality attribute meaning to the experience of illness, and are often the only support found for understanding and coping with the difficulties

imposed by symptoms and ways of managing stress situations[10].

According to the above, this study is justified by the need to understand how religiosity and spirituality permeate the course of CKD of people in dialysis treatment, and aims to analyze the perception of patients who perform hemodialysis on religiosity and spirituality in the course of chronic kidney disease and hemodialysis treatment.

Method

It is a descriptive study, of qualitative nature, prepared according to the international guide for the preparation of qualitative research articles Consolidated Criteria for Reporting Qualitative Research (COREQ), developed in a clinic specialized in renal diseases, located in Guarapuava (PR). The clinic is a private institution, which provides services to the Unified Health System (UHS) and provides dialysis and HD treatment for patients from Guarapuava and the 5th Regional Health Center, with capacity for 150 patients.

The study participants were patients who underwent hemodialysis in the aforementioned clinic. The inclusion criteria were: to be over 18 years, once the clinic performs care only of adult patients and does not provide pediatric nephrology care, children being referred to other centers; be in dialysis treatment for at least six months, what was justified by this time interval being related to the elaboration of reality, that is, different times of hemodialysis mark the acute character or chronicity in front of the routine of hemodialysis, thus marking different elaborations on the part of the patient, of the lived reality; carriers or not of other pathologies associated with CKD. Patients with communication difficulties and with unpreserved cognitive domain were excluded, based on a pre-selection performed in the medical records of each patient by the nurse and the clinic psychologist.

The collection of speeches took place in January 2022, using two techniques: observation and interview. The interviews were individual, in an appropriate location, recorded with the aid of a recorder and then transcribed into Google docs for data processing, grouping of Key Expressions (HEC), creation of Central Ideas (CI) and Anchoring (CA).

The interviews occurred based on an instrument previously developed by the researcher, and contained sociodemographic data for characterization of subjects and guiding questions regarding information related to religion and time of belief.

The technique of the Discourse of the Collective Subject (CSD), a methodology proposed in the late 1990s by Lefèvre and Lefèvre, which is based on the theory of Social Representation, was used to organize the data obtained in the interview[11]. CSDs form a panel of social representations in the form of discourses that seek, based on a series of methodological figures, to rescue collective thinking in a less arbitrary way than what usually occurs in a qualitative research[11].

The methodological bases or operators used by CSD are four: Key Expressions, Central Ideas, Anchoring and Collective Subject Discourse. HEC are excerpts from the speech that reveal the essence of the testimony and describe the content of the argument. Based on the HEC, the CIs and CAs are constituted. The HEC reveal how the individual thinks. CI correspond to a synthesis made by the researcher of the speech emitted by the subject. It is not an interpretation, but the description of the meaning of the testimony. CI reveals what people think. CA is a statement that contains a value, a theory, an ideology, a belief expressed in the discourse that is professed by the subject[11].

To proceed with the construction of the CSD, it is necessary to identify the CIs and CAs. Those that have more meanings, equivalent or even complementary sense are grouped into categories. These categories exist in a way that best express all CI and CA with the same meaning.

Thus, the interviews were analyzed following the steps proposed by the CSD, according to the following six steps: [1] the content of the response of each subject was copied in full in the Speech Analysis Instrument

1 (IAD 1) in the column HEC; [2] identified in each response the HEC for CI and the HEC of CA, if they were present. In the selection process of the HEC, what was not relevant or did not make sense for the research, was excluded; [3] the CIs and CAs were identified and described based on each HEC, placing them in their respective rows; [4] the CIs with the same meaning were grouped, equivalent or complementary, and "tagged" with Roman alphabet I, II, III, followed consecutively in ascending order; [5] created for each grouping (I, II, III, followed consecutively in ascending order) an IC synthesis that best expressed all the HEC and CA with the same sense, with equivalent or complementary sense; [6] the DSC was built using the Speech Analysis 2 (IAD 2) instrument[11].

The categories continue to group discourses of similar meaning, but the meaning of these discourses is not restricted to the categories, incorporating, in addition to them, the respective discursive and argumentative contents present in individual discourses[11].

The research was approved by the Committee of Ethics in Human Research at the *Universidade Estadual do Centro Oeste* (Unicentro), Opinion n. 5.129.620/2021, Certificate of Presentation of Ethical Appreciation (CAAE) 52511421.6.0000.0106.

Results

Regarding gender, 61.53% were cisgender men (n=8) and 38.47% were women (n=5). Regarding the age group, 38.48% were between 50-59 years (n=5), 23.07% between 60-69 years (n=3), the same percentage (23.07%) for 70-79 years, and 15.38% were between 30-39 years (n=2).

The numbers for ethnicity were equal for white 46.16% (n=6) and 46.16% for brown (n=6), and 7.69% were black. Regarding the cities of residence, all participants lived in cities in the state of Paraná, with 76.93% living in Guarapuava, 7.69% in Cantagalo (n=1), 7.69% in Nova Laranjeiras, and 7.69% in Turvo.

In relation to income, 53.84% received wages higher than two minimum wages (MW) (n=7), and 46.16% lower or equal to two minimum wages. It is worth noting that, in January 2022, the minimum wage was equivalent to R$1,212.00. Regarding schooling, incomplete elementary education was highlighted with 38.47% (n=5), followed by complete high school with 23.07% (n=3), higher education 7.69% (n=1), complete elementary education 7.69% (n=1), complete higher education 7.69% (n=1), incomplete higher education 7.69% (n=1), and no study 7.69% (n=1). Of the sample, 46.16 were retired (n=6), 23.07% employed (n=3), 7.69% were absent (n=1), 7.69% received sickness benefits (n=1), 7.69% unemployed (n=1) and 7.69% students (n=1).

The marital status was characterized by 76.93% married (n=10), 15.38% widowed (n=2) and 7.69% unmarried (n=1); and 46.16% living with spouse (n=6); 23.07% with spouse and children (n=3); 15.38% living alone (n=2); 7.69% with husband, daughter and son (n=1); 7.69% with grandson (n=1).

Regarding the clinical variables, 23.07% had type 2 diabetes mellitus (DM2) (n=3); 23.07% nephritis (nephrotic syndrome and glomerulonephritis (GNC)) (n=3); 15.38% for covid-19 (n=2); 15.38% systemic arterial hypertension (HAS) (n=2); 7.69% type 1 diabetes mellitus (DM1) (n=1); 7.69% glomerulolithiasis (n=1); and 7.69% had AH and DM (n=1) (Table 1).

The study included 13 patients on hemodialysis treated in the clinic specialized in renal diseases during the period studied. The following tables 1 and 2 show the results obtained in relation to the sociodemographic and health variables and the religious and spiritual aspects respectively:

Table 1 – Distribution of sociodemographic and health variables of participants undergoing hemodialysis. Guarapuava, Paraná, Brazil – 2022. (N=13)

Variables	Cis Man		Cis Woman		Total	
	N	%	n	%	n	%
Age Group						
70 - 79	1	7.69	2	15.38	3	23.07
60 - 69	2	15.38	1	7.69	3	23.07
50 - 59	5	38.48	-	-	5	38.48
30 - 39	-	-	2	15.38	2	15.38
Ethnicity						
White	4	30.78	2	15.38	6	46.16
Brown	4	30.78	2	15.38	6	46.16
Black	-	-	1	7.69	1	7.69
Income						
Up to 2 Minimum Wages	3	23.08	3	23.08	6	46.16
Over 2 Minimum Wages	5	38.46	2	15.38	7	53.84
Education						
Complete Higher Education	1	7.69	-	-	1	7.69
Higher Education in Course	-	-	1	7.69	1	7.69
Incomplete Higher Education	1	7.69	-	-	1	7.69
Complete High School	2	15.38	1	7.69	3	23.07
Complete Elementary School	1	7.69	-	-	1	7.69
Incomplete Elementary School	3	23.08	3	23.08	6	46.16
Occupation						
On Leave	-	-	1	7.69	1	7.69
Retiree	3	23.08	3	23.08	6	46.16
Sickness Benefit	1	7.69	-	-	1	7.69
Unemployed	1	7.69	-	-	1	7.69
Housekeeper	-	-	1	7.69	1	7.69
Employed	3	23.07	-	-	3	23.07
Marital Status						
Married	7	53.85	3	23.08	10	76.93
Widowed	1	7.69	1	7.69	2	15.38
Single	-	-	1	7.69	1	7.69
Living						
Spouse	5	38.47	1	7.69	6	46.16
Spouse and Child	2	15.38	1	7.69	3	23.07
Spouse, Child and Son in law	-	-	1	7.69	1	7.69
Grandchild	-	-	1	7.69	1	7.69
Alone	2	15.38	-	-	2	15.38
Etiology of Chronic Kidney Disease						
Covid -19	2	15.38	-		2	15.38
Diabetes Mellitus 1	1	7.69	-		1	7.69
Diabetes Mellitus 2	1	7.69	2	15.38	3	23.07
Diabetes Mellitus 2 and Systemic Arterial Hypertension	-	-	1	7.69	1	7.69
Glomerulonephritis	1	7.69	2	15.38	3	23.07
Systemic Arterial Hypertension	2	15.38	-	-	2	15.38
Lithiasis	1	7.69	-	-	1	7.69

Source: created by the authors.

Note: Conventional sign used:

-Numerical data equal to zero not resulting from rounding.

Regarding belief, 38.47% were catholic (n=8); 23.07% evangelical (n=3); and 15.38% had no religion (n=2). It is noteworthy that 69.23% (n=9) of the sample considered themselves religious and practitioners. When asked about what spirituality is, the answers varied between: *All* 38.47% (n=5); *Important* 30.77% (n=4); *Serious* 15.38% (n=2); *Strength* 7.69% (n=1); and *Way of living* 7.69% (n=1) (Table 2).

Table 2 – Religious and spiritual aspects of participants undergoing hemodialysis. Guarapuava, Paraná, Brazil – 2022. (N=13)

RELIGIOUS AND SPIRITUAL ASPECTS	n	%
Religion		
Catholic	8	38.47
Evangelical	3	23.07a
No religion	2	15.38
Feels religious		
Yes	9	69.23
No	4	30.77
What is spirituality?		
Everything	5	38.47
Important	4	30.77
Serious	2	15.38
Strength	1	7.69
Way of living	1	7.69

Source: created by the authors.

The collected data were faithfully transcribed in Google docs to be later presented with the most relevant ECH. In total, 17 HECs were identified, which were analyzed and identified as CIs and CAs. Those that had the same meaning, equivalent or even complementary sense were grouped into three categories: 1) Social support – family, friends and church; 2) Spiritual support – faith, God and prayer; 3) Spirituality: coping and acceptance of diagnosis and treatment.

Chart 1 describes each of the CSDs formulated, based on the analysis of the interviews.

Chart 1 – Collective Subject Discourses constructed through Key Expressions, Central Ideas and Anchoring

CSD 1: Social Support – Family and Friends
My family and friends support me, they know about my problem and are always with me. The church members and the pastor are always by my side, giving me support. They are always praying for me. This has helped me a lot and given me strength.
CSD 2: Spiritual Support – Faith, God and Prayer
If you don't have faith, if you don't have God, you can't do it. I have a lot of faith in God and in Our Lady of Aparecida, because without them I can't live. Religion gave me courage. What helped me the most was prayer. Many times I was feeling bad, I spoke to God and He heard me and helped me. I pray to God and I have faith that He will free me from here. If we have a problem, we pray. I feel very good when I pray. While I'm here, I pray.
CSD3: Spirituality: coping with and accepting diagnosis and treatment
Treatment is something that you have to follow, you have to do, and everything is for God. It took me a year to accept the diagnosis and treatment, because my mother died while undergoing HD, but good things are happening and this increases my faith. After I discovered this disease, my faith grew, I became more attached to God, the psychological force is to have something to trust. We get closer to the spiritual side, to supernatural support. My faith strengthens me, it is one of the reasons I am alive today.

Source: created by the authors.

Discussion

Among the 13 subjects who participated in the survey, 61.53% identified themselves as cisgender men, while 38.47% identified themselves as cisgender women. Data from the 2020 Brazilian Dialysis Census, reports that in July of the same year, the total estimated number of patients in HD in the country was 144,779, with a margin of error of 5% that is, ranging from 137,527 to 152,038, 3.6% more than in July 2019. Of this total, 58% (approximately 83,972 patients) were male[12].

The age varied between 34 and 79 years, with an average of approximately 59 years, since the largest number of subjects were in the 50-59 years age group (38.48%). These data are consistent with the data from the 2020 Brazilian Dialysis Census[12], which shows that the highest prevalence age of HD patients was between 45 and 64 years old, representing 42.5%[12] of the total. It is perceived that the older the age, the greater the search and influence of spirituality and religiosity, which provides help in improving quality of life and support for coping with the disease and its treatment[13].

In the item ethnicity, white (n=6) and brown (n=6) corresponded to 46.16% of the sample. The results of another study[14] are similar in relation to race/color, where 68.3% of the sample were white and 13.8% were brown.

All subjects in this study had income, with an average of approximately R$3,559.00, with a minimum of R$1,200.00 and maximum of R$10,000.00. When analyzing this average, the subjects cannot be considered as low income, since 23.07% have family income of approximately five MS. On the other hand, when analyzed separately, patients are classified in low income, and this is due to the fact that 46.16% of the subjects are already retired or absent and unemployed due to the clinical condition. These data corroborate other national studies of patients undergoing HD, whose percentage of < or = a 2 MS was 48.2%[15]

Regarding schooling, 38.47% had incomplete elementary school and 23.07% complete high school. The low level of education brings to light a population that presents restrictions in the possibility of accessing and understanding information about treatment[15].

In relation to marital status, 76.93% were married; as for the number of individuals residing at the household of the interviewees, 46.16% resided only with their spouse and 23.07% resided with their spouse and child. This fact turns out to be relevant, considering that the dialysis treatment can often be prolonged and exhausting for those who do it. The presence of a companion and other relatives for a patient with chronic disease is essential for health care and for the perception of quality of life. That is, the support of the spouse in this process of illness has been shown to be beneficial for coping with the disease and its treatment[1].

The etiologies that led to the most frequent dialysis treatment were type 2 diabetes mellitus (23.07%) and nephritis (glomerulonephritis and nephrotic syndrome) (23.07%). Study[16] shows decompensated DM as the second etiology for CKD, representing 14.9% of the sample, and nephritis as the sixth etiology of CKD, with systemic arterial hypertension in first place, representing 40.6% of the sample. The Brazilian Dialysis Census 2020[12] presents data similar to that of the study[16], in which SAH and DM have a similar percentage, SAH (32%) and DM (31%). Glomerulonephritis, in turn, is in fifth place, representing 9% of the sample, given that it differs from the results of this study.

Regarding belief, 38.47% were catholic, 23.07% evangelical and 15.38% had no religion; and still 69.23% of the participants considered themselves religious and practitioners. In a study that aimed to evaluate the spirituality and religiosity of chronic renal patients under hemodialysis treatment, the data found were: 57.1% catholic, 14.3% evangelical, 19.1% other religions and 9.5% had no religious belief[17].

Most of the study participants considered spirituality as *everything* and *important*. It should be noted that another study[18] showed that the level of spirituality increased in 56.75% of patients after the diagnosis of CKD.

Recent studies show that religion and spirituality are important for the dialysis patient, since these variables are influential in important aspects of QoL and coping with the disease, and they function as measures to strengthen them in the face of the obstacles they experience[17].

When analyzing the CSD, the first speech described the importance of social support, such as family members, friends, members of the religious community, pastors who offer this support through prayers and the support offered. Social support can be understood as quality of emotional support through the relationships established in social networks and how their presence and/or absence influences the health of individuals. This relationship explains why individuals with a support network of family, friends and/or companions often have better physical and mental health conditions[19].

When the person with CD, especially CKD, has support and care, it is easier to live with CD and treatment less difficult, since he is sure to have people ready when he needs them. Family involvement facilitates the formation of new networks to provide support and care. The support of friends and neighbors improves the confrontation of CD and HD[19]. In a study[20], the author describes that regular religious practices constitute an individual and social good, as well as a powerful response to significant social problems, and also presents that religion acts as a system beyond the personal and existential dimension, establishes the connection with the group, with environmental ecology and, in a general way, with humanity. This may be related to what the participants described when they said that the social support of pastors and church members gave them strength to continue with treatment.

These findings corroborate the second CSD, when they present the importance of spiritual support through faith, prayers, and that without faith, without God it is difficult to achieve, because He provides courage to face difficult moments. A study also shows that people who claim to believe in God tend to have greater satisfaction with life, with subjective well-being, self-esteem and to be more optimistic[20].

Before the CD, prayer becomes a common practice in various moments of daily life. It is used as an important resource of relief, healing and life transformation. In one study, prayer was often used as a method to deal with the physical and emotional burden of chronic renal failure (CKF). The patients participating in the study described that, through this resource, it was possible to deliver their concerns and problems to a higher power, as well as having faith and trust in the will of God, helping them to experience peace and hope[21].

The third CSD brings that spirituality and its resources help in coping and acceptance of disease, because beliefs strengthen and help to maintain treatment and everyday life. As a coping mechanism, spirituality and faith arise as a protective factor based on resilience in the face of inexorable circumstances, enabling the patient new perspectives[22-23]. In addition, spirituality and religiosity contribute to the way these patients deal with the pain caused by CKD and hemodialysis therapy[17].

In the study[24], most family members agreed that spiritual/religious support is a significant source of support for coping with difficult moments. The person with CKD faces life situations that are related to other dimensions, beyond the physical and its clinical picture, needing to deal with the suffering that occurs from the experience of difficult moments, such as rejection, guilt and struggles, in the daily attempt to find the balance of their health. Among the various forms of strengthening, there is the search for the spiritual and religious dimension, in order to help their difficulties and adaptations.

Illness can become a situation of approaching the divine in an attempt to save or solve problems. The closer to the spiritual aspects, the more the family and the subject identify resources to move forward with the disease and treatment. The subject uses religious resources to understand disease, possible death, and learn how to deal with them[25].

It is worth mentioning that the study's limitations are related to the small number of publications on the subject addressed. There is a need for more research and reflection on the subject, as well as the importance of raising awareness and training health professionals about spirituality in their clinical practice, with the aim of ensuring comprehensive care to patients.

The present study brings contributions to research, teaching and professional practice, through results that reveal the importance of spirituality and religiosity, as well as social and family support, as factors that contribute to the acceptance of the diagnosis, treatment and improvement of the quality of life of people with CKF. The results can be used in teaching and professional practice aimed at training qualified professionals to care for people with CKD in its multidimensionality.

Final Considerations

In this study, it was evident the subjectivity present in the impact caused by the diagnosis of CKD and its treatment and in the ways of coping used by patients. In the subjects' speeches, key expressions and central ideas highlighted three categories considered fundamental in the process of coping with the disease: Social Support, Spiritual Support and Spirituality related to the acceptance of diagnosis and treatment.

The family was considered as the meaning of existence for many participants in the study, highlighting the importance of social support from family and friends, which favors the coping with difficulties.

The study also showed that religious practice has a positive relationship with physical, mental health and quality of life, since the reports showed that believing in something superior generates strength to face the limitations imposed by CKF and hemodialysis treatment. Thus, spirituality and religiosity contribute to the acceptance of disease and maintenance of everyday life.

Collaborations:

1 – conception and planning of the project: Tayná Traspadini Stein;

2 – analysis and interpretation of data: Tayná Traspadini Stein, Caliope Pilger, Daniela Viganó Zanoti and Isabella Schroeder Abreu;

3 – writing and/or critical review: Tayná Traspadini Stein, Caliope Pilger, Daniela Viganó Zanoti, Maria Isabel Raimondo Ferraz and Isabella Schroeder Abreu;

4 – approval of the final version: Tayná Traspadini Stein, Nayme Gabriela Afonso Lopes and Isabella Schroeder Abreu.

Competing interests

There are no competing interests.

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