ORIGINAL ARTICLE

Perceptions about the "Mais Médicos" *Program and the Academic Supervision Process*

Percepções acerca do Programa Mais Médicos e do Processo de Supervisão Acadêmica

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KEYWORDS

– Human Resources.

– Doctors.

– Remote Areas.

– Primary Health Care.

ABSTRACT

Introduction: *This study aims to analyze the perceptions of the involved actors about the "Mais Médicos" Program (PMM) and the academic supervision process, its strengths and weaknesses aiming to improve Primary Heath Care practices.* ***Method****: Qualitative study carried out through 05 in-depth interviews with PMM supervising doctors, and 24 interviews with unit managers, 12 Primary Heath Care coordinators, and 07 Secondary Health Care doctors.* ***Results****: Three thematic axes emerged from de analysis: benefits of the program for the municipalities and for the population; the challenges of the supervisory process and the difficulties of the fragmented health system.* ***Conclusions****: The actors' perception of the "Mais Médicos" Program are positive, especially because it brought doctors to municipalities with vulnerable areas, where doctors did not go to and where they did not stay. Supervision is an important support for continuing in-service training; however, it requires a better articulation with the different levels of the health system management. The precariousness of the service network limits the performance of both doctors and supervisors, demonstrating that it is necessary to invest in a solid and effective care network. Moreover, it was once again evident that the population will face a shortage of doctors due to changes in health policies. It is necessary to build more comprehensive policies, that will not only result in sporadic provision of medical care. There is a need for continuous actions, better integrated to the healthcare networks, aiming at an efficient and effective healthcare system.*

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PALAVRAS-CHAVE

– Recursos Humanos.

– Médicos.

– Área Remota.

– Atenção Primária à Saúde.

RESUMO

Introdução: *Este estudo teve como objetivo analisar as percepções dos atores envolvidos acerca do Programa Mais Médicos (PMM) e do processo de supervisão acadêmica, as suas fragilidades e pontencialidades para a melhoria das práticas na atenção primária à saúde.* ***Método:*** *Trata-se de estudo qualitativo, realizado por meio de cinco entrevistas em profundidade com médicos supervisores do PMM, analisados com auxílio do software Iramuteq, e 24 entrevistas com gestores de unidades, 12 coordenadores da atenção básica e sete médicos da atenção secundária, que foram submetidas à análise de conteúdo.* ***Resultados:*** *Da análise surgiram três eixos temáticos: benefícios do programa para os municípios e a população, os desafios do processo de supervisão e as dificuldades do sistema de saúde fragmentado.* ***Conclusões:*** *As percepções dos atores acerca do PMM são positivas, sobretudo porque o programa levou médicos para os municípios com áreas vulneráveis. Antes do PMM, os médicos não tinham interesse em deslocar-se para essas áreas e, quando o faziam, não permaneciam muito tempo nesses locais. A supervisão é importante apoio de formação continuada em serviço, contudo requer que seja mais bem articulada com os diversos níveis de gestão do sistema de saúde. A precariedade da rede de serviços limita a atuação tanto dos médicos como da supervisão, demonstrando que é preciso investir em uma rede de atenção sólida e eficaz. Ademais, ficou evidente que, mais uma vez, a população enfrentará a falta de médicos por causa das mudanças nas políticas de saúde que não priorizam a garantia do acesso universal aos serviços de saúde. É necessária a construção de políticas mais abrangentes que não se limitem ao provimento esporádico de médicos. É imprescindível que haja ações contínuas e mais bem integradas às redes de atenção, visando a um sistema de saúde eficiente e eficaz.*

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INTRODUCTION

Several countries find it difficult to provide medical care in remote and vulnerable areas, and seek to resolve this problem through long-term policies and actions[1-5]. Similar problems can be observed in Brazil[6], despite efforts to improve the distribution of doctors across the country, especially in Primary Health Care (PHC), which is a strategy to improve the population's equitable access to health services[7].

Countries such as Iran, Thailand, Canada, Australia and Japan have approached the issue in a systematic way, and demonstrated that interventions, when fragmented, led to negative results[2,3,8], suggesting the construction of broader policies, based on a continuous and non-sporadic planning process, accompanied by monitoring and evaluation.

The *Mais Médicos* Program (PMM, *Programa Mais Médicos*) was created in 2013, with several strategies to attract, recruit and retain doctors in remote and vulnerable areas. It had an intersectoral articulation, with the involvement of the Ministry of Health (MS), the Ministry of Education (MEC), as well as the states and municipalities. It had three lines of action: a) emergency provision of doctors by hiring Brazilian doctors, Brazilian doctors trained abroad and foreign doctors to work in remote and vulnerable regions[6,9], improving the infrastructure of basic health units (BHU), change in the curricular matrix of medical courses with greater emphasis on PHC and the increase in the number of vacancies[6,9].

Among the program's monitoring and evaluation strategies, academic supervision was highlighted, part of the educational axis with the purpose of strengthening the permanent education policy through the teaching-service integration[10,11]. MEC Normative Ordinance N. 14 of July 9, 2013, provided for the adherence of federal institutions of higher education to the program, which predicted tutoring and supervision for the monitoring of PMM doctors on site [10]. The tutoring aimed at following the academic supervision work process, seeking to encourage the doctors' technical-assistance improvement within the context of strengthening Primary Health Care[10]. Moreover, it aimed at allowing reflections on the work process, on the implementation of the service, teamwork, the territory and its social determinants. The operationalization of supervision occurred through individual and in-person visits, as well as through the use of distance communication tools, such as telephone or internet, aiming to develop actions of second formative opinion, inter-consultation or other activities necessary for medical action improvement[10-12]. It was also the supervisor's responsibility to support doctors in the creation and implementation of intervention projects developed during the Specialization Course in Family Health, carried out by all PMM doctors in the first training cycle[10-12].

Supervision has been adopted for different purposes and strategies by other countries as support for doctors working in remote and vulnerable areas, achieving satisfactory results in the technical improvement of care, in reducing the professionals' feeling of isolation, and certainly in strengthening permanent education[13,14]. And in Brazil, within the scope of the PMM, it was implemented as support for the doctors, aiming at improving the Primary Health Care (PHC) work and management process[15-17].

Considering that this is a relevant strategy for maintaining doctors in remote and vulnerable areas, and the importance of evaluating the program from different perspectives[18], the need to analyze how this process occurred in the PMM is justified, based on the subjects who experienced it. These subjects have relevant perceptions for the understanding of strategic policies/programs, and can provide subsidies for the improvement of new, more robust and long-lasting policies, capable of benefiting the population in a more equitable and fair manner.

Thus, this study aims to analyze the perceptions of the actors involved in the implementation of the *Mais Médicos* Program about the academic supervision process, its weaknesses and potentials for improving Primary Health Care practices.

METHOD

This is a qualitative study, based on social constructionism[19], which allows access to the knowledge shared by a certain social group, and which guide their practices[19]. From this perspective, it was assumed that it is important to understand the perceptions of the actors involved in the process of implementing the program at the local level to better inform the public policies of provision and retention of doctors for vulnerable areas.

The study site is located in the Integrated Region of the Federal District and Surroundings, which involves the municipalities of the state of Goiás, Minas Gerais and the Federal District. This is a region with big socioeconomic contrasts, with municipalities that are called "bedroom towns", with pockets of poverty, and some with extensive rural areas.

In-depth interviews were carried out with five doctors who were also supervisors and, aiming at a methodological triangulation, with 24 unit managers and twelve Primary Care coordinators, and seven doctors working in Secondary Care, to understand the impacts of the supervision process on the work process, the service organization and the health system.

The supervisors' interview script dealt with: Work experience at the PMM, the facilities and difficulties of the supervision process, and the impacts of the end of the PMM. The interview script of the PHC coordinators and the managers of the PHC units contained questions about the work process supervision, its contributions and limitations, whereas that of the Secondary Care doctors addressed the communication/integration of PMM doctors with PHC, as well as with the care network.

The interviews were carried out from April to June 2019 and lasted about 45 minutes each. All subjects signed the Free and Informed Consent Form and the Multicenter Project was approved under number 3,289,154.

All supervisors' interviews were transcribed, henceforth referred to as *corpus*, and analyzed using the Iramuteq (*Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*) software, which allows demonstrating the contents that are shared and agreed upon by a certain social group[20]. Based on the *corpus* processing, 71.92% was classified, which is considered satisfactory[20].

The interviews of the coordinators, the managers of the Primary Care units and the Secondary Care doctors were submitted to content analysis, from the hermeneutic perspective, as they aimed to complement the understanding of the contributions and limitations of the supervision process in the PMM context.

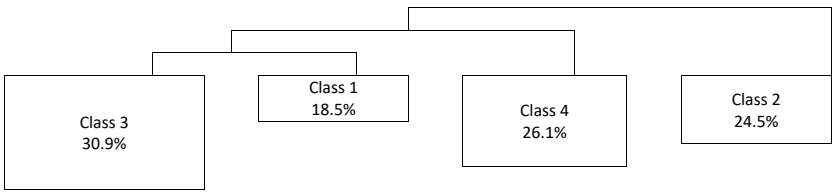
In this study, we chose to use the Descending Hierarchical Classification (DHC), in which the text segments of a *corpus* are classified according to their respective statistically significant vocabularies, in the form of classes[20]. After processing and grouping the occurrences of the words, a dendrogram of the classes is created in the DHC. To create a word dictionary, the program uses the chi-square test (x^2), which reveals the strength of the association between words and their respective class[20]. The dendrogram, in addition to disclosing the classes, demonstrates the link between them, as they are associated with each other[20].

RESULTS

Three thematic axes are observed in the dendrogram (Figure 1): the first one with class three, with 30.9% and class one with 18.5%, which are interconnected, deals with the benefits of the program for the municipality and for the population. The second thematic axis, with class four (26.1%) discloses the challenges of the supervision

Figure 1

Dendrogram: Perceptions of the *Mais Médicos* Program and academic supervision



Class 3	Class 1	Class 4	Class 2
stay	good	activity	care
municipality	world	supervision	primary
want	never	process	secondary
well	now	sense	medical record
population	salary	management	hospital
know	meeting	maintain	electronic
understand	scholarship	practical	ECU
health center	complain	education	duty
condition	now	supervisor	accessible
reason	always	supervise	water
form	answer	larger	beautiful
different	receive	relationship	Sobradinho
beginning	same	need	door
pharmacy	month	difficulty	counter-reference
return	give	vacancy	reference
political	look	student	city
face	speak	DF	tertiary
arrive	enter	provision	exist
cooperative	colleague	enlargement	example
Brazilian	much	tutoring	Goiás
hire	problem	promotion	district
interest	pay	loco	Brasilia
patient	turn off	enlarge	use
less	think	find	train
manager	day	management	rural
really	deal	continue	classification

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process. And the third axis addresses communication and articulation difficulties with the health care network.

The words contained in class three showed that the program brought in doctors to "stay" where doctors "did not go" and "did not stay".

> *I think it was a gain, because the doctors from the "Mais Médicos Program" are in places that did not use to have doctors. And when there were (doctors), the turnover was very high, so I think they brought continuity to the follow-up, which certainly benefited the population (Subj 2).*

However, at the beginning, there was a certain fear of the program, especially due to the arrival of a large number of foreign doctors, particularly Cubans. There was a certain suspicion regarding the technical competence of these doctors, due to the lack of diploma revalidation.

> *I thought that the doctors in the "Mais Médicos Program" were not physicians, because they were not accredited by the Regional Council of Medicine (CRM), they only had authorization from the Ministry of Health to exercise their activities. So they were not physicians. The pharmacists at the pharmacies, whether the pharmacy belonged to the municipality or was a private one, did not want to fill the prescriptions prescribed by the doctors who belonged to the "Mais Médicos program". This resulted in some suits, including from Council to Council, which have already been solved at this time (Subj 5).*

In this same class, it was highlighted that the municipalities have not been able to afford the number of doctors needed for PHC. In this sense, the contribution of the payment of wages compatible with the complexity of PHC work by the Ministry of Health showed to be fundamental. Moreover, it became evident that a program with less political interference, which is very common in the municipalities, was feasible and sometimes compromises both the way the work process is organized, especially regarding the priority of the population care, as well as the doctors' contractual safety.

In class one, the benefits of the program were highlighted, such as the wages that were paid in the form of scholarships. Despite the precarious nature of the contractual bond, it allowed the professionals to receive payment regularly, which is not the case when payments are made directly by the municipalities. However, it was disclosed that, for the continuation of the program or similar, it would be important to create a career of positions and salaries for doctors.

Another benefit that was highly valued by doctors was the opportunity to take the distance specialization course in Family Health, with a learning methodology that is still unusual in the health area, which was developed with the support of the universities.

> *The primary benefit that I see is specialization. Even though it is Distance Education (DE). Our country does not have a very good culture, it does not have a positive view of this issue of distance courses and education. But it is very good, and that is the main thing (Subj 2).*

Finally, it was demonstrated that the dismissal of some doctors due to the end of the program will bring great losses to the municipalities, which will not be able to recompose the PHC units with the necessary number of doctors, due to the lack of financial resources to pay salaries compatible with PHC complexity, as well as other types of support, required to attract doctors to regions with precarious infrastructure and/or away from large centers.

> *And if the "Mais Médicos Program" ends, it will be chaos. The municipalities do not have the funds to maintain this unit functioning as it is, with the doctor, nurse, everyone. They do not. (Subj1).*

Axis two contains class four, which deals with the academic supervision process that focuses on a formative process that aimed to contribute to the synthesis between theory and practice.

> *We have the title of Academic Supervisor. I think it is 80% of the Program objective, as I see it. That is what is imparted to us when we enter the program, as a doctor or supervisor, that is to train this professional. And to consolidate this theoretical and academic knowledge with daily practice (Subj1).*

In this class, the importance of the supervision process was highlighted, especially for foreign doctors, particularly for Cubans, who were called cooperative members and were the vast majority, and who had their training based on another context.

> *There was a very large number of cooperative doctors. Their reality, their studies, is quite different. So there was an even greater need for this link, of what they studied there in the country where they graduated (Subj 1).*

It was observed that Brazilian doctors were more resistant to the supervision process. In this sense, they stated that supervision involved the challenge of dealing with their own peers, who have the same level of academic training, and therefore they did not easily accept the provided guidelines.

> *I think the most challenging thing in supervision is dealing with people. You are talking to colleagues who are doctors just like you, and they often do not welcome any feedback that you need to give. And that has created some problems for me, people who did not respond well to some comments. But I understand that it is my supervision role over there, anyway (Subj 2).*

This class also showed the *modus operandi* of the supervision process, which involved monthly in-person meetings, and remote support, through the use of communication technologies, which allows the discussion of "cases" and the resolution of clinical doubts.

> *Well, there is in-person supervision, which we do once a month. But we are also available to them during the month, as remote support. The supervision is carried out by WhatsApp, basically. They send a photo of the skin lesion, the result of the exam, they report cases to discuss. And we have these discussions on a daily routine (Subj 2).*

Moreover, regional meetings were held every four months, aiming to articulate the problems and difficulties identified during the supervision

process with the unit management, as well as the municipal and state managements.

> *We have meetings inside the state committee, together with supervisors and UnB staff, who carry out the entire process of pedagogical monitoring to identify the difficulties or obstacles that have occurred within the region (Manager AB 11).*

However, they observed difficulties in the supervision process. Most managers of the PHC units did not clearly perceive the performance of the supervision or stated that the supervisors had a very restricted and superficial performance, with little involvement with the care provided at the PHC units.

> *Well, the experience we have with the supervisor is not a very good, no. He comes here, asks some questions and such. But it is not just asking questions, they have to analyze them in practice (Manager 1).*

The supervisors demonstrated that the lack of involvement of the unit manager made it difficult to create intervention strategies by listening to doctors who work in the daily routine of services.

> *I think that, in reality, the biggest difficulty is this matter of the managements participating a little more in the supervision activities. Because sometimes they are in the Unit, but they say only 'hi' and leave. So it would be a privileged space, for listening to what the doctor is reporting as difficulty, and what I, as a supervisor, could help in the service, by offering some proposal of intervention to the management (Subj 4).*

PHC managers more clearly observed the benefits of the supervision process, as a dialogical process, listening to the doctors who are working in the daily routine of the services, as well as in the management.

> *They (the supervisors) are well, let us say like that, they are democratic. They listen to the management, they listen to the doctor, what the doctor is having difficulty with at the municipality. So there is always a dialogue that facilitates communication. (Manager AB 8).*

In this sense, the PHC coordinators said that with the end of the program, the municipalities will lose the in-service training process, which is carried out through the supervision strategy, and constitutes relevant institutional support.

> *With the end of the contract, we have lost many professionals, and consequently the field supervisors as well. This is a problem for us, because it makes it difficult. You start to lose this great capacity, this in-service training that supervisors provide to professionals. Something that we cannot do yet within the structure of the Health Department at present. Having an institutional supporter, a regional supporter, discussing their daily problems with the professionals on a regular basis (Subj 11).*

The last thematic axis addresses the challenges of supervision in the context of a fragmented health system, especially that of communication with other health care levels. The electronic medical record was a strategy created to improve communication between doctors at the three levels of care, aiming to favor the continuity of care. However, although it has been implemented in many municipalities, it has not been used due to infrastructure problems, lack of system connection, and lack of personnel training.

> *The DF implemented the electronic medical record, but we have a lot of difficulty regarding the internet access. This hinders the use of some tools that could be used as academic support for Telemedicine, to have access to the Primary Care notebooks (Subj 7).*

Moreover, it was discovered that the electronic medical record only allows communication with services at the municipal level, as it has no connection with the state and federal levels and, therefore, it does not allow communication with the other levels of care, i.e., secondary and tertiary, which are under the responsibility of different government spheres.

> *It is only now that doctors are taking courses to adapt to the program of the municipal electronic medical record. This municipal electronic medical record does not yet communicate with the state electronic medical record (Subj 1).*

Difficulties in establishing PHC as the health system coordinator were observed due to the lack of a culture that values PHC as a system gateway and organizer, both by doctors and the population.

They demonstrated this difficulty regarding the access to order tests, as well as to obtain their results for the implementation of care in a timely manner.

> *Very precarious. The access to order tests, and then to receive the test results, for instance, gynecological prevention: We have a pap smear test result in up to six months. An in situ carcinoma, in which the woman receives the result after six months and then has to go through the whole process of seeking specific care for her case (Subj 1).*

They also verified that the mechanisms of referral and counter-referral are not clearly established in the health system. Therefore, there are difficulties in referring users who need services from the other levels of care.

DISCUSSION

The perceptions of the actors involved in the PMM are quite positive, of a program that brought doctors to the municipalities located in remote and vulnerable areas, where doctors did not go and did not stay, therefore allowing the population to have access to basic health services[21-24], which is guaranteed in the current Constitution as a right of all citizens, but still finds difficulties to be guaranteed, especially in the PHC, which provides the services to the vast majority of the population[7,21].

In this sense, several studies have shown that the PMM mainly allowed the concretization of the principle of equity, through the distribution of doctors in PHC according to the criteria of social vulnerability and of specific populations[21-25]. It provided the presence of doctors in areas of difficult access, of extreme poverty, far from large centers, in the outskirts of metropolitan regions, and indigenous populations, as well as riverside, *quilombolas*, and rural populations[21-25], who were previously excluded from the system.

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Nevertheless, it must be considered that, initially, part of the medical corporation was in opposition to the program, mainly due to the arrival of a large number of Cuban doctors[26], which contributed to the creation of negative perceptions of these doctors and the program[27-29]. The lack of diploma revalidation was the central argument, since Cuban doctors had obtained a single registration through the Ministry of Health to perform only the activities defined by the program. At the time, the Federal Council of Medicine demanded from the PMM the communication of the list of doctors and the place where they would work, under the argument that they would be subject to the current laws regarding professional, civil, criminal and ethical liability[27]. In addition to requiring training actions, which culminated in the process of welcoming doctors to improve proficiency in the Portuguese language, presenting SUS principles and guidelines, along with the monitoring and evaluation by academic tutors[28].

The population, by having the opportunity of having contact with these professionals in their daily lives and recognizing their good practices, was able to deconstruct the derogatory perceptions of doctors and, consequently, to redefine the importance of the program.

It is clear the perception that such a large scale program was not made viable only with municipal financial resources, it was also the responsibility of the federal government, more precisely of the Ministry of Health[20,22], regarding the payment of doctors' salaries compatible with the complexity of PHC in vulnerable areas. The link between the program and the Ministry of Health provided a greater sense of contractual safety to the doctors and, therefore, greater freedom to develop their work, with less political interference from the municipalities. However, the type of contractual bond was considered to be precarious, since doctors were paid through a scholarship[21,22], which did not include social and labor guarantees[27].

Other studies have confirmed that good wages, combined with other types of benefits, help to fix doctors in remote and vulnerable areas; however, they do not guarantee it[29], requiring other material and immaterial support, such as the possibility of making shared clinical decision-making, having access to specialists, among others.

In the PMM, the municipalities had the counterpart to guarantee the doctors' housing, food and travel; to implement or support family and community medicine residency programs and ensure that the professionals had the necessary time for improvement activities[6]. Studies have shown that the possibility of continuing training, as well as the availability of time for studies to keep the knowledge related to the area updated, are factors that have strongly contributed to the retention of health professionals in remote areas[30,31].

A positive perception of academic supervision was observed, as a formative process that uses the dialogical approach to carry out the synthesis between theory and practice, allowing a reflective praxis, which makes it possible to improve the performance in PHC. The power of supervision lies in stimulating the search for new knowledge[31,32] through problematizations, based on the concrete reality[16,17], which presents increasing complexity in PHC due to the deterioration of the population's quality of life in recent years as a result of the economic recession[33].

The supervision process was more appreciated by the foreign doctors (the cooperative members) than by the Brazilian doctors, possibly because this type of support has become more useful for those who had their training and experience in other realities, helping them in improving their practices, as well as in recognizing the territory.

The supervision, together with other contractual benefits of the PMM, brought as a relevant modification the full-time permanence of the doctors in the units, which allowed the treatment of a larger number of patients, especially of spontaneous demand, besides being able to count on their presence for other activities in the unit and in the community, which promoted user satisfaction[23]. In this regard, it is reiterated that the supervision process through a strategy of reality problematization can contribute to the greater commitment of doctors to their own work[14], which is extremely relevant for PHC, requiring the formation of bonds between professionals and users[23].

The supervision has been used as a support strategy in several countries with remote areas, aiming to assist doctors in making the most timely and correct decisions[15-17]. However, its introduction in PHC practices requires a change in professional culture, with greater appreciation of this type of support since the academic training of doctors[14].

The methodological strategy of distance support also has been used in many countries with remote and vulnerable regions to support the supervision process, and it has proved to be quite fruitful[13]; from the professionals' point of view, an increased feeling of self-confidence, satisfaction has been observed, and from the point of view of care, greater access to specialists, in addition to making appropriate decisions in a timely manner was noted. However, in the context of the PMM, although implemented in most municipalities, difficulties were observed due to the precariousness of the technological infrastructure, especially internet access in the municipalities.

This study showed that the supervision process did not satisfactorily involve all the subjects responsible for the management of PHC services, particularly the unit managers, who are essential to support the most comprehensive interventions. It is at this level of management that changes can be made, both in the work process and in the organizational structure, and some interferences in the care network.

Communication and articulation difficulties with the other levels of the health system were observed. The lack of a health care network was seen as the greatest difficulty for doctors, as they are unable to solve the problems of users who need other services besides PHC.

It was therefore evident that, although it is necessary to recruit and train family doctors and implement Family Medicine Services, which the PMM did, it is not enough to produce effective PHC, because a solid and effective referral network is necessary, as well as an adequate investment in infrastructure of health care networks. This observation leads us to consider how the best support for the municipalities to integrate the new PMM doctors into the networks would have been important, as well as a better investment in technological infrastructure, perhaps through the requirement of accumulated incentives through related policies, such as the 'Improvement in the Quality of Primary Care Program' (PMAQ, *Programa de Melhoria da Qualidade da Atenção Básica*), the improvement of the network and others, so they could be better integrated to prevent the fragmentation of care in PHC.

Regarding the limitations of the study, the interviews with tutors were not carried out to obtain another counterpoint to the supervision process. Moreover, data collection was carried out almost at the end of the program, when the interviewees were experiencing difficult feelings related to the dismissal of their colleagues (the doctors), which may have interfered with the construction of the perceptions of the supervision process and the program.

CONCLUSIONS

The perceptions of the actors involved in the PMM are quite positive, of a program that brought doctors to municipalities with remote and vulnerable areas, which were places where doctors did not go and did not stay, therefore allowing the population to have access to basic health services with equity. The supervision process was understood as an important support for continuing in-service training, which helps in the clinical decision-making process. However, it needs to be better articulated with the different levels of management to improve its capacity to function in the local health system. Moreover, it was observed that the precariousness of the service network limits the performance of both doctors and supervisors, demonstrating that recruiting and training doctors and implementing Family Medicine Services is not enough, being necessary to invest in a solid and effective care network.

Nevertheless, it was evident that, once again, the population will face a shortage of doctors due to changes in health policies, which do not prioritize ensuring universal access to health services.

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AUTHORS' CONTRIBUTION

Helena Eri Shimizu worked on the study conception and methodological design and the writing of the manuscript. Leonor Maria Pacheco Santos and Mauro Niskier Sanchez provided field research guidance. Thomas Hone and Christopher Millett contributed with data discussion and Matthew Harris contributed with data discussion and the critical review of the article.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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