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Organization of care for people with overweight and obesity in the state of Rio de Janeiro: the view of Primary Health Care professionals

Organização do cuidado às pessoas com sobrepeso e obesidade no Estado do Rio de Janeiro: o olhar de profissionais da Atenção Primária à Saúde

Abstract

Introduction: Obesity and other chronic non-communicable diseases have been responsible for 63% of deaths worldwide and require an organized health system for the care of these people. ***Objective***: This study aims to analyze the organization of care for overweight and obese people in municipalities in the State of Rio de Janeiro from the view of primary health care professionals. ***Methods***: 265 professionals from 26 municipalities, who took a training course on this subject, participated. The professionals were nominated by managers; they registered via electronic questionnaire containing information related to their personal and professional profile and to the organization of care for obese people. The questions were objective and discursive. The open questions were analyzed by exploration, categorization, and interpretation of the material. ***Results***: Weaknesses were identified in terms of strategies, instruments, systems, and processes, which are fundamental for the organization of care with the view to a comprehensive health care, among them the scarcity of financial resources, insufficient staff, change in management, turnover of professionals and the (in)comprehension of the role of each professional in the care of obesity.
Final considerations: The findings confirm the need to invest in strategies and actions to qualify the offer of health services and the care for overweight and obese people.

Keywords: Obesity. Care. Integrality in Health. Primary Health Care.

Resumo

Introdução: A obesidade e outras doenças crônicas não transmissíveis têm sido responsáveis por 63% das mortes no mundo e demandam um sistema de saúde organizado para o cuidado a essas pessoas. ***Objetivo***: Este estudo tem como objetivo analisar a organização do cuidado às pessoas com sobrepeso e obesidade em municípios do Estado do Rio de Janeiro na perspectiva de profissionais da Atenção Primária à Saúde. ***Métodos***: Participaram 265 profissionais de 26 municípios que realizaram um curso de formação nesta temática. Os profissionais foram indicados por gestores e

realizaram inscrição via questionário eletrônico, com informações relativas ao seu perfil pessoal e profissional e à organização do cuidado às pessoas com obesidade, com perguntas objetivas e discursivas. As questões abertas foram analisadas por exploração, categorização e interpretação do material. ***Resultados***: Foram identificadas fragilidades em termos de estratégias, instrumentos, sistemas e processos que são fundamentais para a organização do cuidado na perspectiva da atenção integral à saúde, dentre elas a escassez de recursos financeiros, equipe insuficiente, mudança de gestão, rotatividade de profissionais e a (in)compreensão do papel de cada profissional para o cuidado da obesidade. ***Considerações finais***: Os achados ratificam a necessidade de investir em estratégias e ações para qualificar a oferta de serviços de saúde e o cuidado às pessoas com sobrepeso e obesidade.

Palavras-chave: Obesidade. Cuidado. Integralidade em saúde. Atenção Primária à Saúde.

INTRODUCTION

Chronic non-communicable diseases (NCDs), including obesity, account for 63% of global deaths, thus it is one of the priority public health issues. In Brazil, they represent 72% of the causes of death and affect more sharply the segments with lower income and education.[1]

Data from the 2021 Vigitel (Surveillance of Risk and Protection Factors for Chronic Diseases by Telephone Inquiry) study indicate that, within the adult population (≥18 years) of the Brazilian state capitals and the Federal District, the frequency of overweight was 57.2%; it is higher among men (59.9%) than among women (55.0%). Regarding obesity, the prevalence was 22.4%, similar among women (22.6%) and men (22.0%).[2] The 2019 National Health Survey – confirms the increase in overweight and obesity in adults in the country, as it reached 60.3% and 25.9%, respectively.[3] This scenario demands integrated public policies and multidisciplinary and intersectoral approaches that focus on the different factors conditioning obesity.

The Brazilian government has been developing programs, strategies, and actions for the promotion, prevention, and treatment of NCDs and obesity, with emphasis on: the Plan for Coping with NCDs;[4] the Intersectoral Strategy for the Prevention and Control of Obesity;[5] and the Feed Guides, for the adult population and for children under 2 years old[7] – official instruments of the Ministry of Health containing information regarding the Promotion of adequate and healthy eating, including the Protocol for the Use of the Feed Guidelines for the Brazilian Population in the dietary orientation of adult people with obesity, hypertension, and diabetes mellitus.[8] This set of initiatives induces public policies, programs, and actions to support, protect and promote the health and the food and nutritional security of Brazilians.

In Rio de Janeiro, the State Plan for Coping with NCDs[9] stands out. It aims to promote the development and implementation of effective, integrated, sustainable and evidence-based public policies for the prevention and control of NCDs and their risk factors. In spite of this set of policies, it is difficult to revert this scenario as it demands to associate individual care with actions to modify the obesogenic environment.[10] This implies consolidating an organized health system and overcoming the constant fragmentation of points of care that hinders communication and the provision of continuous, equitable and quality care.[11] Within the scope of Health Care Networks (Redes de Atenção à Saúde (RAS)), Lines of Care (LC) are strategic for the organization of services, as they enable the integration of the network and the construction of flows between users and services, which contributes to respond to the health needs of the population.[12] To qualify the care for overweight and obese individuals, the Ministry of Health established the Line of Care for Overweight and Obesity – Linha de Cuidado para Sobrepeso e Obesidade (LCSO), which redefines the guidelines and attributions of the focal points for the organization of promotion, prevention and treatment actions.[13,14]

In the view of health professionals, the implementation of nutritional care practices for people with obesity in the context of the Health Care Networks is still a challenge, due to factors such as: lack of time to perform counseling aimed at promoting healthy lifestyle habits, presence of other health problems, low adherence of users to treatment and insufficient access to instructional material, among others.[15]

The care for people with obesity demands multidisciplinary teams and, due to the multifactorial nature of the disease, requires actions beyond the health sector.[16] However, it is in this sector that the problems occur and care is provided, then it is essential to understand how the organization of care actions for overweight and obese people are arranged at the local level, as well as the difficulties and potentialities of the health sector. Therefore, the objective of this study was to analyze the organization of care for people with overweight and obesity in Primary Health Care in municipalities of the state of Rio de Janeiro under the gaze of health professionals involved in a training course on the subject.

METHODS

The study is part of the project "Actions to control and confront obesity in the state of Rio de Janeiro - research, training, monitoring and dissemination - Ações de controle e enfrentamento da obesidade no estado do Rio de Janeiro – pesquisa, formação, monitoramento e difusão", coordinated by the Universidade do Estado do Rio de Janeiro (UERJ) and is identified as the Coping Obesity Project (Projeto de Enfrentamento da Obesidade (PEO-ERJ)), which received funds from the Conselho Nacional de Desenvolvimento Científico e Tecnológico - CNPq, call no. 26/2018. The project aims to support the implementation of actions to control and tackle overweight and obesity in municipalities of the state of Rio de Janeiro, through three lines of action: Research and Development; Evaluation, Monitoring and Dissemination; and Training. For this last line, the public notice recommended prioritizing the training of municipal managers and health workers who work in the Extended Family Health Centers and Primary Care (Núcleos Ampliados de Saúde da Família e Atenção Básica (NASF-AB)). Thus, two courses were offered for the qualification of care actions for people with obesity, aiming to contribute to the organization of the Line of Care for Overweight and Obesity - LCSO in the municipalities. One of the courses was directed to Primary Health Care - PHC managers and the other to health professionals.

For the course to health professionals, at least one municipality was selected from each of the nine administrative regions of the state of Rio de Janeiro that met at least one of the following inclusion criteria: having, in 2018, Extended Family Health Center teams; having received, in 2017 and/or 2018, resources from the Food and Nutrition Fund , the Healthy Growth program (Programa Crescer Saudável), the Food and Nutrition Surveillance and the Health Academy program (Programa Academia da Saúde); and/or having a Food and Nutrition Technical Area active in 2018. Municipalities having partnerships with universities that make up the Coping Obesity Project – Rio de Janeiro (PEO-ERJ) team were also invited. For the distribution of vacancies, the number of Extended Family Health Center - plus general vacancies was considered, excepting the municipality of Rio de Janeiro where, as there were many NASFs, vacancies were made available for only them in the health care network. The municipality that did not have NASF received at least six vacancies; therefore 709 vacancies were offered in total.

Thirty-four municipalities were previously selected and two more requested to participate after presenting the project at events at the State Health Secretariat and the Council of Municipal Health Secretariats. In all, 27 municipalities signed the agreement to participate in the PEO-ERJ. From then on, municipal managers were instructed to indicate PHC professionals to participate in the course, making up a total of 501 professionals.

After the indication, the professionals were contacted by email and asked to fill out an semi-structured and self-applicable electronic questionnaire - Google Forms, in order to know the healthcare network of the municipalities, and also collaborate to make adjustments in the content of the training course. The questionnaire was divided into three modules. In Module 1, the questions sought to understand the personal and professional profile (profession, position, time working in PHC and type of relationship).

In Module 2, the actions for prevention and care of obesity were mapped, including actions for the Promotion of Adequate and Healthy Eating - , and the situations that favor or hinder the development of these actions were identified, in addition to the knowledge about educational materials, social facilities available in the territory and issues related to the organization of the service and nutritional follow-up. In this module, all questions had, among the pre-established response options, also an open field, in addition to three discursive questions that demanded the categorization of the answers, regarding: a) the factors that favor the development of care actions for overweight/obesity; b) the description of the care flow for people with overweight/obesity; and c) Promotion of Adequate and Healthy Eating actions carried out with other sectors.

In Module 3, a survey of expectations regarding the course was carried out. The present study refers to the results of Modules 1 and 2. The questionnaire was answered by 422 health professionals from the 27 municipalities who participated in the training course. However, only 265 (62.8%) professionals from 26 municipalities in eight of the nine administrative regions signed the Free and Informed Consent Form, allowing the use of data.

The data referring to the objective questions were organized in an Excel spreadsheet and analyzed using simple frequency percentages. The data analysis of the discursive questions was performed through thematic categorization. The project was approved by the Research Ethics Committee of the Hospital Universitário Pedro Ernesto - HUPE/UERJ (CAAE-Certificate of Ethical Appraisal - 10514819.8.0000.5259 and Ethics Opinion No. 3.288.424) and by the Research Ethics Committee of the Municipal Health Secretariat of Rio de Janeiro (CAAE - 10514819.8.3001.5279 and Ethics Opinion No. 3.686.093).

RESULTS

Profile of the participants

The professionals were distributed in eight health administrative regions, and the Centre-South Region was the one that responded most to the survey regarding the vacancies available for this region (86.1%), followed by the North Region (63,2%), Baixada Litorânea (56,7%), Metropolitan Area II (47,1%), Médio Paraíba (45,5%), Serrana (44,4%), Ilha *Grande* Bay (40%) and Metropolitan Area I (23,9%).

Most respondents declared themselves white (60.8%), female (90.9%) and were in the age group up to 39 years (59.5%). Among the professional categories, the participation of nutritionists (47.5%) and nurses (24.2%) was the largest; 60.4% of participants had a level of specialization (Table 1).

Regarding the position and function performed, 20.4% of the participants reported being linked to the Extended Family Health Care Center ; 16.6% held a coordination or local management position (health unit manager); and 58.9% held the position corresponding to their professional category in Primary Health Care – PHC.

Participants had worked for less than five years in the current position (50.6%) and more than five years in PHC (55.9%). As for the employment relationship, 40.8% of professionals are public servants, 26.8% have direct temporary contracts and 22.3% have contracts with Social Health Organization.

Table 1. Academic and professional profile and employment relationship of the professionals. Rio de Janeiro-RJ, 2019.

Academic and professional profile	(n)	(%)
Gender		
Female	241	90.9
Male	24	9.1
Age		
30 to 39 years old	116	43.7
40 to 49 years old	68	25.6
Up to 29 years old	42	15.8
Above 50 years old	39	14.7

Table 1. Academic and professional profile and employment relationship of the professionals. Rio de Janeiro-RJ, 2019.(Continues).

Academic and professional profile	(n)	(%)
Race/colour		
White	161	60.8
Brown	76	28.7
Black	26	9.8
Indigenous	2	0.8
Profession		
Nutricionist	126	47.5
Nurse	64	24.2
Psychologist	17	6.4
Doctor	15	5.7
Physical Educator	13	4.9
Physiotherapist	13	4.9
Others*	17	6.4
Academic Degree		
Specialization	160	60.4
Under graduation	78	29.4
Master	21	7.9
PhD	4	1.5
Post-doc	2	0.8
Current position or function		
Corresponding to his/her professional category***	156	58.9
Extended Family Health Centers**	54	20.4
Coordinators, Advisors, Supporters, Supervisors and Managers	43	16.3
Resident****	12	4.5
Length of time working in current position		
Less than 2 years	62	23.4
From 2 to <5 years	72	27.2
From 5 to 8 years	68	25.7
More than 8 years	63	23.8
Length of time working in PHC		
Less than 2 years	47	17.7
From 2 to <5 years	70	26.4
From 5 to 8 years	67	25.3
More than 8 years	81	30.6
Work relationship with the Municipal Health Secretariat		
Public servant	108	40.8
Temporary contract and other legal entity contracts and independent contractors	71	26.6
Contract by Social Organization and signed labor contract or cooperatives	59	22.3
Others *****	15	5.6
Total	265	100.0

(*) Lawyer, Social Worker, Speech Therapist, Sanitarian, Dentist and Occupational Therapist.

(**) Social Worker, Physical Educator, Physiotherapist, Speech Therapist, Endocrinologist, Nutritionist, Psychologist, Sanitarian, Supervisor, Occupational Therapist.

(***) Nurse, Physician, Psychologist, Physiotherapist, Physical Educator, Social Worker, Health Agent, Speech Therapist, Occupational Therapist.

(****) Residents: Dentist, Physical Educator, Nurse, Nutritionist, and Psychologist.

(*****) Scholarship owners, residents, doctors from Mais Médicos program, and independent freelance professionals (RPA).

Logistical support tools: medical records and referral flows

In Table 2, it is observed that 54.7% of respondents still use physical medical records to register medical care and 66.1% use the e-SUS AB electronic medical record. When asked about the kinds of information registered in the nutritional and dietary follow-up of the patients, 94% of professionals reported weight and height were the main data recorded, especially by nutritionists and nurses. The Body Mass Index (BMI) was indicated by 79.2% of professionals, while food intake by 53.6% of them.

Tabela 2. Types of medical records and information registered about nutritional and dietary monitoring in PHC. Rio de Janeiro-RJ, 2019.

Types of medical records	(n)	(%)
e-SUS Primary Care medical record	85	32.1
Physical medical record	73	27.6
Physical, e-SUS Primary Care medical record	56	21.1
Municipality electronic medical record	25	9.4
Municipality electronic medical record, e-SUS Primary Care medical record	10	3.8
Physical medical record, Municipality electronic medical record	7	2.6
Physical medical record, Municipality electronic medical record. e-SUS Primary Care medical record	7	2.6
Physical medical record and others (SISVAN and e-gestor)	2	0.8
Recorded nutritional follow-up information*		
Weight / Height	249	94.0
Body Mass Index (BMI)	210	79.2
Breastfeeding	159	60.0
Nutritional Guidance	154	58.1
Food consumption	142	53.6
Don't know	17	6.4

***** This question allowed more than one answer.

Regarding the existence of an organized flow for the care of people with overweight and obesity in the municipality, concerning the closed component of the question, 43.4% of the professionals confirmed this organization and 34% could not inform. In the open component, which provided discursive answers, the respondents highlighted issues that do not necessarily refer to the flow of care, but to the work process developed by PHC professionals, such as individual/group care, or the performance of NASF professionals and the nutritionist.

Concerning the mechanisms of regulation/referral for care in other equipment of the Health Care Network of the municipality, 67.5% of professionals reported to rely on some system of regulation and 65.7% registered referral and counter-referral forms.

Actions for the prevention and control of overweight and obesity

When asked about the actions to prevent obesity within the team, 94.0% of professionals mentioned carrying out individual consultations, 68.3% highlighted intersectoral actions in the school environment and 61.9% carried out specific actions to encourage the practice of physical activity.

Among the equipment/programs that put in place care actions for overweight/obesity, 53.6% of the participants mentioned the Specialty Outpatient Clinics; 46.8%, the Health Academy Program (Programa Academia da Saúde); 34.7%, the National School Nutrition Program - (Programa Nacional de Alimentação Escolar); and 14.7% did not know (Table 3).

Table 3. Activities, equipment, and programs used for overweight/obesity prevention and control. Rio de Janeiro-RJ, 2019.

Activities Developed*	(n)	(%)
Individual Consultations	249	94.0
Intersectoral Actions of Health and Education in the school environment (Health in Schools Program - PSE)	181	68.3
Specific actions to encourage the practice of physical activity	164	61.9
Scheduled collective activities with the groups and their families	163	61.5
Matrix support: case studies. unique therapeutic projects. team meetings, home care	135	50.9
Shared consultations	126	47.5
Permanent education actions for the professionals	95	35.8
Specific actions for the elaboration and execution of culinary workshops	*50*	18.9
Don't know	9	3.4
Others	2	0.8
Equipment and programs that participate in the care of overweight/obese people*		
Medical specialty outpatient clinic	142	53.6
Health Academy	124	46.8
National School Nutrition Program	92	34.7
Sports Poles	56	21.1
Don't know	39	14.7
Residents' association	21	7.9
Religious Institutions	20	7.5
Philanthropic entities	10	3.8
None	10	3.8
Other: NASF; academia popular; CATAN; groups	9	3.4

* This question allowed more than one answer.

Regarding the material used for technical support for the care of people with overweight/obesity, the most mentioned were the Food Guide for the Brazilian population) and the Primary Health Care Notebooks, both published by the National Health Ministry of Brazil (Table 4).

Table 4. Frequency of educational materials used as technical support in Overweight and Obesity Care. Rio de Janeiro-RJ, 2019.

Educational Materials	(n)	(%)
Primary Care Notebooks	168	63.4
Eating Guide for the Brazilian Population	167	63.0
Eating Guide for children under two years old	116	43.8
Guidelines for assessment of food consumption markers in Primary Care	70	26.4
Material prepared by the municipality/state itself	68	25.7
Don't know	38	14.3
Framework for Food and Nutrition Surveillance in Primary Care	37	14.0

Table 4. Frequency of educational materials used as technical support in overweight and obesity care. Rio de Janeiro-RJ, 2019.(Continues).

Educational Materials	(n)	(%)
Ordinances organizing the line of care for the treatment of obesity	37	14,0
Food and Nutrition Education Framework for Public Policies	36	13.6
Instructional Manual for the Organization of the Regional Obesity Line of Care	22	8.3
Intersectoral Strategy for the Prevention and Control of Obesity: recommendations for states and municipalities	21	7.9
None specific	19	7.2
Perspectives and challenges in the care of people with obesity in the SUS: results of the laboratory of innovation concerning the management of obesity in health care networks	19	7.2
Others	8	3.0

***** This question allowed more than one answer

Regarding the factors that favor the development of actions to prevent and control overweight and obesity in the municipality, the professionals pointed out issues related to the existence of actions and support groups for guidance and awareness, multidisciplinary team and matrix support, encouragement of physical activity, individual care, management support and expansion/coverage of the Family Health Strategy . It must be observed that 7.9% (21) of professionals answered that there were no actions related to this subject or did not know.

Among the factors that can hinder the development of these actions, the most mentioned were lack of financial resources, lack of information and insufficient staff (57.7%, 54% and 51.7%, respectively). Issues related to lack of financial resources; lack of information; change of management and/or professional turnover and insufficient staff were also identified (Table 5).

Table 5. Factors that hinder the development of actions for coping with overweight/obesity. Rio de Janeiro-RJ, 2019.

Hindering factors *	(n)	(%)
Lack of financial resources	153	57.7
Lack of information	143	54.0
Change of management and/or professional turnover	139	52.5
Insufficient staff	137	51.7
Inadequate physical space, equipment, and furniture	127	47.9
Invisibility of the disease	102	38.5
Lack of urban mobility to join the actions	92	34.7
Low political interest	85	32.1
I don't identify	16	6.0
Others	9	3.4

*****This question allowed more than one answer.

As for the dialogue with other sectors for the development of actions for the Promotion of Adequate and Healthy Eating, 31.3% of the participants answered that they usually do it in their territory, and 49.1% did not know. In response to the open questions that set up the data collection instrument, professionals indicated that they carry out individual and collective assistance; activities in schools through the Health in School Program - (Programa Saúde na Escola (PSE)); strategies to promote, protect and support

breastfeeding and complementary feeding; continuing education activities, rounds of conversation, among others.

DISCUSSION

Organization of care for overweight and obese people in the state of Rio de Janeiro: about professionals and services

The survey showed a higher percentage of women among the professionals who enrolled for the course, which is supported by the literature that indicates a trend towards feminization of the workforce in PHC and a lower propensity among doctors, white people and postgraduates[17,18]

The most frequent professional category was nutritionist. As the professionals who attended the course were nominated by managers, they are likely to consider that obesity is only a matter of responsibility or, primarily, concerning the nutritionist and therefore it demands "uniprofessional" care. Even if the nutritionist is the protagonist and qualifier of actions related to food and nutrition,[19] interdisciplinarity is essential for the care of people with overweight and obesity, due to the complexity and multidimensionality of the matter.[13, 18-20] Interdisciplinary work indicates "the possibility that a professional practice is reconstructed over the experience of the other professional practice, and both are transformed for the intervention in the reality in which they are inserted".[21] Although it had been recommended the participation of professionals from the Extended Family Health Centers in the course, a small part of the group attended. The implementation of the Extended Family Health Centers to support the Family Health Strategy - allowed the expansion and diversification of professionals and emphasized the logic of matrix support,[22] where the nutritionist is inserted as an expressive category in the State of Rio de Janeiro, the fourth most frequent professional category.[23] In 2017, new movements for the financial induction for the management of PHC actions were raised. In the republishing of the National Primary Health Care Policy, NASF was renamed Extended Family Health Center and Primary Health Care - Núcleo Ampliado de Saúde da Família e Atenção Básica (NASF-AB). Among the many changes, it is worth mentioning those observed in the modalities and composition of the teams, which do not present criteria or pre-established requirements for their organization and exempt the manager from using the team typology NASF-AB. From this untying, the municipal manager has the autonomy to assemble his multidisciplinary teams, which, with no specific funding and induction criteria for these teams building, can lead to decision making processes that do not consider NASF professionals as priorities.[24,25] Thus, discussions on the new National Primary Health Care Policy showed possible risks and setbacks for the achievements obtained with the strengthening of PHC in Brazil and reinforce a State increasingly focused on the private sector[26]

The length of time professionals have worked in PHC is another characteristic to be analyzed. For Campos & Malik,[27] the permanence of health professionals in the Family Health Strategy, especially doctors and nurses, is a crucial factor for the effectiveness of PHC, since the model is based in the bond between the team professionals and users. Consequently, it contributes to the efficiency in the application of health actions and user participation in their care.[28] The length of time of work may be related to turnover, associated with the low salary policy, precarious working conditions, full workload requirement, low conditions for professional progression, low commitment of professionals and lack of previous training compatible with the model proposed by the Family Health Strategy.[29]

The analysis of the organization of care involves from the logistical support instruments to the actions of promotion, prevention, and treatment of obesity. Most professionals point out that they use the electronic medical record e-SUS AB, although the use of physical records or the association between different types of

records is observed for registering the care services. The use of unified and electronic medical records for the management of user health conditions, especially in chronic conditions, is essential for care coordination and facilitates programming, monitoring and the regulatory flow. The improvement of the e-SUS is essential to qualify the performance in the FHS, potentialize a more effective and appropriate planning[30] and allow larger volume of information transfer to the Food and Nutrition Surveillance System, which is an important tool for the management of food and nutrition care actions.[31] However, the Food and Nutrition Surveillance needs to progress, both in the collection, recording and information analysis.[32]

In this study, most professionals report the existence of regulatory systems that are essential for the organization of care[33,34] and consolidation of the Lines of Care for Overweight and Obesity, since their inexistence causes, more often and more intensely, self-regulation by the user, so he can ensure access to health care.

The actions and services must be organized in an integrated manner, so that the Lines of Care for Overweight and Obesity are structured based on the description of care flows and the regionalization of services.[35] The construction of a LC demands to understand and recognize the actions in the Health Care Network, based on the longitudinality of care and the importance of each crucial point, beyond the practices that occur in the PHC and considering that this set of actions can promote positive impacts on health and well-being of the people involved. According to Malta & Merhy,[36] the construction and existence of a LC presuppose actions at the macro and micropolitical levels, which include, among others, those related to the organization of the network of services, surveillance and health information and the identification of risk groups in the field of macro-organization. From the perspective of micropolitics, it points to the team's role in coordinating care, the link and the caregiver's accountability. From this aspect, the authors suggest that the LC should be user-centered, which reinforces the use of soft technologies, adequate therapeutic project, expansion of access to services, in addition to interventions on the social determinants of health.

Regarding the care flow, the professionals' reports present a peculiar organization of each service/health unit, and do not express the idea of a network flow that could involve other crucial points present in the network of services in the municipality/region.

It is worth noting that the proposals to build LC stand out for considering new conceptions about care and the conditioning factors of the health and disease process, and demand a redefinition of the relationships between professionals and users, and of the knowledge and practices to meet indeed the health needs of individuals.[10]

Actions developed for the prevention and control of overweight and obesity in the municipalities of Rio de Janeiro State: potentialities and challenges

Professionals tend to prioritize individual consultations, although they report carrying out operative groups, actions in schools through the Health in School Program and physical activity practices. Brito et al.[37] found similar results and suggest that the actions are still based on the curative model, which, among other causes, can be explained by issues related to the organization of access, the teams' work overload, the need for training and the appreciation of these activities. It is important to point out that, from the perspective of integral care, both individual and collective actions presuppose promotion, prevention, and treatment actions, which complement each other in response to the needs.[38]

The actions in schools, in general, are often mentioned by Family Health Strategy professionals as they contribute to tackle overweight and obesity. Despite the power of these actions, Ramos et al.[20] point out,

among the challenges of the Health in School Program, the coverage limited to schoolchildren, and the scope of actions restricted to specific subjects.

The Health Academies were also quoted as health promotion actions and can strengthen partnerships between the coordination and technical areas. However, they require a better structure, their own resources and a multi-professional team that can organize itself in an integrated manner[39]

Another challenge for health professionals is to keep up to date with the constant production of evidence and information. Although some professionals know the Primary Health Care Notebooks and food guides, there is a lack of knowledge of guiding documents for obesity care, also published by the Health Ministry, reaffirming some findings of other studies.[40,41] This reinforces the need to facilitate the professionals' access to these documents in the health units and to expand the permanent health education processes.

Difficulties in the effectiveness of multiprofessional care and the recognition of the lack of preparation to deal with the complexity of obesity were also mentioned by Burlandy et al.[10] Among the strategies suggested by the authors, it is essential to rescue in the processes of training and dialogue with professionals some principles and guidelines already indicated in government documents that guide the care, among them the co-responsibility, the valuation of additional gains, besides weight loss and multiprofessional work. This approach is in line with the proposal of the training course in question in this study.

In the logic of Health Care Networks, it is important to consider how the set of health actions and services is organized to meet the health needs of the population. The implementation of the Lines of Care for Overweight and Obesity can strengthen and qualify health care, ensuring timely access of users to health services and offering care according to individual needs and the proposed protocols. To this end, it is necessary to strengthen the Health Care Networks with infrastructure, funding, workers qualification and reinforcement of the multiprofessional team.

CONCLUSIONS

The study identified weaknesses in terms of strategies, instruments, systems, and processes that are fundamental to the organization of care from the perspective of integral health care. The actions in multidisciplinary teams as care strategy suited to the multidimensionality of obesity still need to be strengthened and the registration tools and information systems, which are fundamental to the health planning process, need to be consolidated. The (in)comprehension of the role of each professional in the Family Health Strategy and Primary Health Care teams for obesity care suggests that the interprofessional and intersectoral action requires professional qualification to expand this care beyond the individual or prescriptive care.

In the context of instruments and systems, which have repercussions on work processes and care, weaknesses were identified in the use of the unified electronic medical record, with potential impact on the Food and Nutrition Surveillance System - Sistema de Vigilância Alimentar e Nutricional- SISVAN. Although most professionals mention the existence of referral and counter-referral mechanisms, their reports do not indicate that there is a clearly defined flow of actions described for each node of the Health Care Network, which is also an important element for the organization of care processes. Some factors that professionals pointed out as being challenges for the implementation of actions are directly related to the dimension of the institutional and management context, particularly: the shortage of financial resources; insufficient teams; and changes of managers and turnover of professionals, also considering the different employment contracts.

Despite these weaknesses, including the consolidation of flows in the light of the Lines of Care for Overweight and Obesity, the municipalities have been developing actions to prevent and control obesity, establishing referral and counter-referral mechanisms, which are essential for the organization of care, and promoting some articulation with other sectors besides health, especially through actions developed in schools. Considering the complexity of obesity and its multifactorial character, the organization of care demands the strengthening of matrix support actions and permanent health education as strategies that can also contribute to induce new care experiences and articulation among different professionals and sectors.

LIMITATIONS OF THE STUDY

The professionals who participated in the study were nominated by the municipalities selected non-randomly, according to the criteria for participation in courses offered by the project. Thus, it is not possible to make inferences related to health region of the State of Rio de Janeiro.

REFERENCES

1. Malta DC, Andrade SSC de A, Oliveira TP, Moura L de, Prado RR do, Souza M de FM de. Probabilidade de morte prematura por doenças crônicas não transmissíveis, Brasil e regiões, projeções para 2025. Rev bras epidemiol. 2019;22:e190030.

2. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de Análise em Saúde e Vigilância de Doenças Não Transmissíveis. Vigitel Brasil 2021: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico: estimativas sobre frequência e distribuição sociodemográfica de fatores de risco e proteção para doenças crônicas nas capitais dos 26 estados brasileiros e no Distrito Federal em 2021 / Ministério da Saúde, Secretaria de Vigilância em Saúde, Departamento de Análise em Saúde e Vigilância de Doenças não Transmissíveis. Brasília: Ministério da Saúde, 2021.

3. Instituto Brasileiro de Geografia e Estatística (IBGE). Pesquisa Nacional de saúde: 2019: atenção primária à saúde e informações antropométricas: Brasil / IBGE, Coordenação de Trabalho e Rendimento. Rio de Janeiro: IBGE, 2020.

4. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de Análise de Situação de Saúde. Plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis (DCNT) no Brasil 2011-2022. Brasília: Ministério da Saúde, 2011.

5. Câmara Interministerial de Segurança Alimentar e Nutricional. Estratégia Intersetorial de Prevenção e Controle da Obesidade: recomendações para estados e municípios. Brasília, DF: CAISAN, 2014.

6. Brasil. Ministério da saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Guia alimentar para a população brasileira. 2. ed. Brasília: Ministério da Saúde, 2014b.

7. Brasil. Ministério da Saúde. Secretaria de Atenção Primaria à Saúde. Departamento de Promoção da Saúde. Guia alimentar para crianças brasileiras menores de 2 anos / Ministério da Saúde, Secretaria de Atenção Primaria à Saúde, Departamento de Promoção da Saúde. – Brasília: Ministério da Saúde, 2019.

8. Brasil. Ministério da Saúde. Orientação alimentar de pessoas adultas com obesidade, hipertensão arterial e diabetes mellitus: bases teóricas e metodológicas [recurso eletrônico] / Ministério da Saúde, Secretaria de Atenção Primária à Saúde, Universidade de Brasília. – Brasília: Ministério da Saúde, 2022.

9. Secretaria de Estado de Saúde do Rio de Janeiro. Subsecretaria de Atenção à Saúde, Subsecretaria de Vigilância em Saúde. Plano de Ações Estratégicas para o Enfrentamento das Doenças Crônicas Não Transmissíveis (DCNTs) no Estado do Rio de Janeiro, 2013-2022. Rio de Janeiro, 2012.

10. Burlandy L, Teixeira MRM, Castro LMC, Cruz MCC, Santos CRB, Souza SR de, et al. Modelos de assistência ao indivíduo com obesidade na atenção básica em saúde no Estado do Rio de Janeiro, Brasil. Cad Saúde Pública. 2020;36(3):e00093419.

11. Mendes EV. As redes de atenção à saúde [Internet]. Organização Pan-Americana da Saúde; 2001. [citado 15 de dezembro de 2021, Acesso em: 31 out. 2022.]. Disponível em:http://repositorio.asces.edu.br/jspui/handle/123456789/1314.

12. Viana AL d'Ávila, Bousquat A, Melo GA, Negri Filho AD, Medina MG. Regionalização e Redes de Saúde. Ciênc saúde coletiva. junho de 2018;23(6):1791–8.

13. Brasil. Ministério da Saúde. Portaria MS nº 424, 19 de março de 2013. Redefine as diretrizes para a organização da prevenção e do tratamento do sobrepeso e obesidade como linha de cuidado prioritária da Rede de Atenção à Saúde das Pessoas com Doenças Crônicas. Diário Oficial da União. Brasília, DF, 19 mar. 2013b. Seção 1, p.55/56.

14. Brasil. Ministério da Saúde. Gabinete do Ministro. Portaria nº 425, de 19 de março de 2013. Estabelece regulamento técnico, normas e critérios para a Assistência de Alta Complexidade ao Indivíduo com Obesidade. Diário Oficial da União. Brasília, DF, 19 mar. 2013b. Seção 1, p. 59/63.

15. Lopes MS, Freitas PP de, Carvalho MCR de, Ferreira NL, Menezes MC de, Lopes ACS. Is the management of obesity in primary health care appropriate in Brazil. Cad Saúde Pública. 2021;37(suppl 1):e00051620.16.

16. Borges SAC, Porto PN. Por que os pacientes não aderem ao tratamento? Dispositivos metodológicos para a educação em saúde. Saúde debate. junho de 2014; 38:338–46.

17. Marsiglia RMG. Perfil dos trabalhadores da atenção básica em saúde no município de São Paulo: região norte e central da cidade. Saude soc. dezembro de 2011;20(4):900–11.

18. Carvalho ALB, de Ouverney ALM, Carvalho MGO de, Machado NM da S. Enfermeiros (as) gestores (as) no Sistema Único de Saúde: perfil e perspectivas com ênfase no Ciclo de Gestão 2017-2020. Ciênc saúde coletiva. janeiro de 2020;25(1):211–22.

19. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Contribuições dos Núcleos de Apoio à Saúde da Família para a Atenção Nutricional [recurso eletrônico] / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica. – Brasília: Ministério da Saúde, 2017.

20. Ramos DB das N, Burlandy L, Dias PC, Henriques P, Castro LMC, Teixeira MRM, et al. Propostas governamentais brasileiras de ações de prevenção e controle do sobrepeso e obesidade sob perspectiva municipal. Cad Saúde Pública. 2020;36(6):e00116519.

21. Araújo MB de S, Rocha P de M. Trabalho em equipe: um desafio para a consolidação da estratégia de saúde da família. Ciênc saúde coletiva. abril de 2007;12(2):455–64.

22. Amparo-Santos L, França SLG, Reis ABC (org.). Obesidade(s): diferentes olhares e múltiplas expressões. Salvador: Universidade Federal da Bahia; Universidade Federal do Recôncavo da Bahia; Universidade do Estado da Bahia; Ministério da Saúde, 2020.

23. Castro ALB de, Machado CV. A política federal de atenção básica à saúde no Brasil nos anos 2000. Physis. junho de 2012;22(2):477–506.23.

24. Secretaria de Saúde. Governo do Estado do Rio de Janeiro. Panorama das equipes do Núcleo de Apoio à Saúde da Família no estado do Rio de Janeiro. 2021. Disponível em: https://www.saude.rj.gov.br/comum/code/MostrarArquivo.php?C=Mzc5NTA%2C. Acesso em: 15 nov. 2021.

25. Novo financiamento da atenção básica: possíveis impactos sobre o Nasf-AB [Internet]. Cebes. [citado 15 de dezembro de 2021]. Disponível em: http://cebes.org.br/2020/02/novo-financiamento-da-atencao-basica-impactos-sobre-o-nasf-ab/. Acesso em: 31 out. 2022.

26. Giovanella L, Franco CM, Almeida PF de. Política Nacional de Atenção Básica: para onde vamos? Ciênc saúde coletiva. abril de 2020;25(4):1475–82.

27. Campos CV de A, Malik AM. Satisfação no trabalho e rotatividade dos médicos do Programa de Saúde da Família. Rev Adm Pública. abril de 2008;42(2):347–68.

28. Schimith MD, Lima MAD da S. Acolhimento e vínculo em uma equipe do Programa Saúde da Família. Cadernos de Saúde Pública. 2004; 20:1487–94.

29. Seidl H, Vieira S de P, Fausto MCR, Lima R de CD, Gagno J. Gestão do trabalho na Atenção Básica em Saúde: uma análise a partir da perspectiva das equipes participantes do PMAQ-AB. Saúde debate. outubro de 2014; 38:94–108.

30. Facchini LA, Tomasi E, Dilélio AS. Qualidade da Atenção Primária à Saúde no Brasil: avanços, desafios e perspectivas. Saúde debate. setembro de 2018; 42:208–23.

31. REDENUTRI. Saiba mais sobre a prática da Vigilância Alimentar e Nutricional. 14 de julho de 2016. [citado em 15 de dezembro]. Disponível em: http://ecos-redenutri.bvs.br/tiki-read_article.php?articleId=1636. Acesso em: 31 out. 2022.

32. Brandão AL, Reis EC dos, Silva CVC da, Seixas CM, Casemiro JP. Estrutura e adequação dos processos de trabalhos no cuidado à obesidade na Atenção Básica brasileira. Saúde debate. setembro de 2020;44(126):678–93.

33. Barbosa DVS, Barbosa NB, Najberg E. Regulação em Saúde: desafios à governança do SUS. Cadernos Saúde Coletiva. 2016; 24:49–54.

34. Bastos LBR, Barbosa MA, Rosso CFW, Oliveira LM de AC, Ferreira IP, Bastos DA de S, et al. Práticas e desafios da regulação do Sistema Único de Saúde. Revista de Saúde Pública. 2020; 54:25.

35. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Diretrizes para o cuidado das pessoas com doenças crônicas nas redes de atenção à saúde e nas linhas de cuidado prioritárias. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica. – Brasília: Ministério da Saúde, 2013c.

36. Malta DC, Merhy EE. O percurso da linha do cuidado sob a perspectiva das doenças crônicas não transmissíveis. Interface-Comunicação, Saúde, Educação. 2010; 14:593–606.

37. Brito GEG de, Mendes A da CG, Neto PM dos S, Farias DN de. Perfil dos trabalhadores da Estratégia Saúde da Família de uma capital do nordeste do Brasil. Revista de APS. [Internet]. 2016 [citado 15 de dezembro de 2021];19(3). Disponível em: https://periodicos.ufjf.br/index.php/aps/article/view/15770. Acesso em: 31 out. 2022.

38. Mattos RA. Os sentidos da integralidade: algumas reflexões acerca dos valores que merecem ser defendidos. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: IMS-UERJ/Abrasco;2001;39-64.

39. Cavalcante EFL. Planejamento e coordenação de ações de alimentação e nutrição: enfrentamento do sobrepeso e da obesidade no município do Rio de Janeiro [PhD Thesis]. 2017.

40. Figueiredo ATT de, Tavares FC de LP, Silveira PRRM, Costa EC, Oliveira AA de, Lira PIC de. Percepções e práticas profissionais no cuidado da obesidade na Estratégia Saúde da Família. Revista de Atenção à Saúde [Internet]. 23 de julho de 2020.

41. Araújo FK, Mourão GMJ, Costa MCB, Alberto NSLMC, Pereira RG, Ramos CV. Atenção nutricional para obesidade em unidades básicas de saúde. Revista Brasileira de Obesidade, Nutrição e Emagrecimento, 2019; 13 (79):385-93..

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