

## Constructs and criteria for diagnosing the primary approach to overweight in Brazil and Portugal: Convergences and divergences

Constructos e critérios para diagnóstico da abordagem primária do excesso de peso no Brasil e Portugal: Convergências e divergências

Constructos y criterios diagnósticos para el abordaje primario del sobrepeso en Brasil y Portugal: Convergencias y divergencias

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**Luciane da Graça da Costa<sup>1</sup>**

ORCID: <https://orcid.org/0000-0002-1892-2471>

São Paulo State University (UNESP), São Paulo, Brazil

E-mail: [lucianedagdacosta@hotmail.com](mailto:lucianedagdacosta@hotmail.com)

**Adriana Aparecida Oliveira Barbosa<sup>2</sup>**

ORCID: <https://orcid.org/0000-0001-9112-2801>

São Paulo State University (UNESP), São Paulo, Brazil

E-mail: [adrianaoliveirabarbosa@outlook.com](mailto:adrianaoliveirabarbosa@outlook.com)

**Flora Correia<sup>3</sup>**

ORCID: <https://orcid.org/0000-0001-9632-0751>

Institute of investigation and Innovation in Health Sciences, University of Porto, Porto, Portugal

E-mail: [floracorreia@fcna.up.pt](mailto:floracorreia@fcna.up.pt)

**Isabel Monteiro<sup>4</sup>**

ORCID: <https://orcid.org/0000-0003-1536-0351>

Department of Sciences, University Institute of Health Sciences, CESPU and URAP, ACeS Porto Ocidental, ARS North, Porto Portugal

E-mail: [isabelmpmonteiro@gmail.com](mailto:isabelmpmonteiro@gmail.com)

**Débora Isabel Fernandes Claudio<sup>5</sup>**

ORCID: <https://orcid.org/0000-0002-6738-8834>

Clinical Nutrition Specialist, ARS Norte, URAP, Porto, Portugal

E-mail: [deboraifclaudio@gmail.com](mailto:deboraifclaudio@gmail.com)

**Teresa Alexandra Oliveira Rodrigues<sup>6</sup>**

ORCID: <https://orcid.org/0009-0001-9417-4217>

North Regional Health Administration, Department of Public Health and ACeS Gaia, Portugal

E-mail: [teresarodrig@gmail.com](mailto:teresarodrig@gmail.com)

**Maria Rita Marques Oliveira<sup>7</sup>**

ORCID: <https://orcid.org/0000-0003-1226-4364>

São Paulo State University (UNESP), São Paulo, Brazil

E-mail: [maria-rita.oliveira@unesp.br](mailto:maria-rita.oliveira@unesp.br)

### Abstract

This study used a questionnaire to gather information from experts in Portugal and Brazil on their approach to obesity. The objective of this study was to identify and discuss convergence and divergence of an instrument for evaluating public policies to combat obesity based on the theoretical logical model of Brazil's primary care policy. With this, we evaluated the diagnostic criteria for this instrument and its applicability in PHC in Brazil and Portugal. The first stage was construction and evaluation. Using the Delphi method, we evaluated four dimensions with Brazilian experts: primary healthcare organization, management, public policy for overweight people, and health system performance.

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<sup>1</sup> Postgraduate Program in Food and Nutrition at the Faculty of Pharmaceutical Sciences, in the área of Nutritional Sciences, São Paulo State University (UNESP), Araraquara, São Paulo, Brazil.

<sup>2</sup> Graduate Program in Nursing, The Medical School (FMB), São Paulo State University (UNESP), Botucatu, São Paulo, Brazil.

<sup>3</sup> Institute of investigation and Innovation in Health Sciences, University of Porto, Porto, Portugal.

<sup>4</sup> Department of Sciences, University Institute of Health Sciences, CESPU and URAP, ACeS Porto Ocidental, ARS North, Porto Portugal.

<sup>5</sup> Clinical Nutrition Specialist, ARS Norte, URAP, Porto, Portugal.

<sup>6</sup> Nutritionist specialized in Community Nutrition and Public Health, North Regional Health Administration, Department of Public Health and ACeS Gaia, Portugal.

<sup>7</sup> Department of Human Sciences and Nutrition and Food Sciences, Institute of Biosciences, São Paulo State University (UNESP), Botucatu, São Paulo, Brazil.

In the second stage, we submitted the form to Portuguese experts, who disagreed with the dimensions and criteria. This form was subsequently modified and reissued. Experts disagreed and agreed on certain points, using Brazil's logical theoretical model for PHC as a reference. The classification of plausible assessment criteria for primary healthcare differs among experts in both countries. Portugal with its plausible criteria focuses more consolidated PHC, better-established protocols, and patient centric care, however plausible criteria for Brazilians approach to overweight is intersectoral and centered on territory and community. No external funding nor grants of any nature were involved in this work.

**Keywords:** Primary Health Care; Obesity; Brazil; Portugal; Evaluation of Public Health Policies.

### Resumo

Este estudo utilizou um questionário para reunir informações de especialistas em Portugal e Brasil sobre sua abordagem em relação à obesidade. O objetivo era identificar e discutir a convergência e divergência de um instrumento para avaliar políticas públicas de combate à obesidade com base no modelo lógico-teórico da política de atenção primária à saúde do Brasil. Com isso, avaliamos os critérios diagnósticos para esse instrumento e sua aplicabilidade na APS no Brasil e em Portugal. A primeira etapa foi a construção e avaliação. Utilizando o método Delphi, avaliamos quatro dimensões com especialistas brasileiros: organização da atenção primária à saúde, gestão, políticas públicas para pessoas com sobrepeso e desempenho do sistema de saúde. Na segunda etapa, submetemos o formulário a especialistas portugueses, que discordaram das dimensões e critérios. Esse formulário foi posteriormente modificado e reemitido. Os especialistas discordaram e concordaram em certos pontos, utilizando o modelo lógico-teórico do Brasil para a APS como referência. A classificação de critérios plausíveis de avaliação para a atenção primária à saúde difere entre os especialistas em ambos os países. Portugal, com seus critérios plausíveis, concentra-se em APS mais consolidada, protocolos mais bem estabelecidos e cuidado centrado no paciente. No entanto, os critérios plausíveis para a abordagem brasileira à obesidade são intersetoriais e centrados no território e na comunidade. Não houve financiamento externo ou concessões de qualquer natureza envolvidos neste trabalho.

**Palavras-chave:** Atenção Primária à Saúde; Obesidade; Brasil; Portugal; Avaliação de Políticas de Saúde Pública.

### Resumen

Este estudio utilizó un cuestionario para recopilar información de expertos en Portugal y Brasil sobre su enfoque hacia la obesidad. El objetivo era identificar y discutir la convergencia y divergencia de un instrumento para evaluar políticas públicas de combate a la obesidad basado en el modelo lógico-teórico de la política de atención primaria de Brasil. Con esto, evaluamos los criterios diagnósticos para este instrumento y su aplicabilidad en la Atención Primaria de Salud (APS) en Brasil y Portugal. La primera etapa fue la construcción y evaluación. Utilizando el método Delphi, evaluamos cuatro dimensiones con expertos brasileños: organización de la atención primaria de salud, gestión, políticas públicas para personas con sobrepeso y desempeño del sistema de salud. En la segunda etapa, sometimos el formulario a expertos portugueses, quienes discreparon en cuanto a las dimensiones y criterios. Posteriormente, este formulario fue modificado y reemitido. Los expertos discreparon y estuvieron de acuerdo en ciertos puntos, utilizando el modelo lógico-teórico de Brasil para la APS como referencia. La clasificación de criterios plausibles de evaluación para la atención primaria de salud difiere entre los expertos de ambos países. Portugal, con sus criterios plausibles, se enfoca en una APS más consolidada, protocolos mejor establecidos y cuidado centrado en el paciente. Sin embargo, los criterios plausibles para la aproximación brasileña a la obesidad son intersectoriales y centrados en el territorio y la comunidad. No se recibió financiamiento externo ni subvenciones de ninguna índole en este trabajo.

**Palabras clave:** Atención Primaria de Salud; Obesidad; Brasil; Portugal; Evaluación de Políticas de Salud Pública.

## 1. Introduction

Brazil and Portugal, despite being far apart, share similarities in language, culture and healthcare approaches (Costa et al., 2021). Obesity-related chronic diseases influenced the healthcare policies of both nations. We set out to evaluate the methods by which the healthcare systems addressed obesity. The objective of this study was to identify and discuss convergence and divergence of an instrument for evaluating public policies to combat obesity based on the theoretical logical model of Brazil's primary care policy.

The approach to contain the increase in obesity in the population in a global syndemic (Swinburn et al., 2019), is complex and requires the efforts of many sectors. Primary healthcare (PHC) plays an important and strategic role in this situation. The World Health Organization (WHO), the main extra-national influencer, has called for discussions, established a consensus, and supported countries to elaborate and implement health policies combating obesity.

The Alma-Ata Declaration (World Health Organization, 1978), giving way to the International Conference on PHC, the Ottawa Letter (World Health Organization, 1986), and later the Adelaide Declaration (World Health Organization, 2017) introduced the world to a comprehensive concept of PHC, which is characterized by strong concerns for human rights, social justice and health equity. To advance along the path of this concept, public health policies require an integrated approach from all sectors that have implications for health. Policies for health protection should consider universal rights. The strengthening of PHC, considering contributory social determinants, is likely to ensure this (World Health Organization, 2014).

The WHO Commission on Social Determinants of Health states that health and human development are interlinked, which is why intersectoral planning and the articulation of actions must consider health an important factor in sustainable economic development (World Health Organization, 2007). Brazil has substantial social inequities and, in a nation like Brazil, and it is important to develop policies that are responsive to the needs of both health and human development, which may not be as well aligned as in Portugal. In this vein, commitment to the Alma-Ata vision has been adapted and adjusted to the reality of each country, giving rise to different approaches to health (Pan American Health Organization, 2007).

Public policy design involves decisions, compromises and setting of priorities to establish guidelines in a social and historical context. These aspects can be represented in a theoretical logical model (TLM) that can be used as a tool to construct and evaluate policies (Cassiolato and Guerres, 2010). However, to this point we have not found an existing framework to perform comparisons between PHC policies for obesity. The objective of this study was to identify and discuss convergence and divergence of an instrument for evaluating public policies to combat obesity based on the theoretical logical model of Brazil's primary care policy.

## 2. Method

Using the Delphi method (Jones and Hunter, 1995), we conducted a study to develop a consensus proposal on how to diagnose the primary approach to overweight. The first stage of this work was in Brazil, and the second in Portugal. The Portuguese stage also featured three expert panels (Rubio et al., 2003).

After adjusting for the Portuguese environment, in the second stage, we adapted the analyses to align with the Brazilian National Program for Healthy Eating. These adaptations included the specific requirements of the Integrated Strategy for the Promotion of Healthy Eating and the Integrated Assistance Process of pre-obesity. The work maintained the purpose and number of original questions. Five Portuguese experts evaluated the tool and obtained a content validity index (ICV) of less than 0.50.

In view of this result, we prepared a revised instrument for Portugal, excluding matters considered irrelevant in the first round. In the second iteration, the expert panel technique (Rubio et al., 2003) allows the interaction between experts to reach a consensus. The first of the three expert panels comprised two researchers, three managers, and two primary care (PC) professionals. The process involved sending the instrument to Portuguese PC technicians and managers for evaluation in a pilot study. However, at this stage, we realized some issues were not yet fully resolved, so we convened a second panel of experts. The panel included three Portuguese researchers with expertise in primary care management and patient support in Portugal. After that, we carried out another Delphi round with 11 experienced Portuguese experts, returning content validity index scores of  $ICV=0.82\pm0.10$  and  $0.76\pm0.04$ , mean  $\pm$  SD for essentiality and adequacy, respectively. In a third panel of experts, all questions with an ICV less than 0.78 for essentiality and adequacy were discussed and adjusted to meet the experts' suggestions.

Through the process of validation and selection of criteria and questions by Brazilian and Portuguese experts, an opportunity arose to assess the theory behind the PHC policy at the core of the approaches to overweight in both countries. The TLM designed by Alves et al. (2019) was adopted as the Brazilian TLM by our research team, keeping the components and

results related to the constructs of each dimension and the criteria found in the two instruments in the model. The criteria that grouped the selected questions were represented in a comparative study.

### 3. Results

A comparison between the dimensions and the number of questions present in the final version of the instrument for each country is shown in Table 1. The Brazilian instrument was finalized into four dimensions of analysis and 209 questions, including the process of care in the healthcare unit, management at the municipality level, local implementation of national policy guidelines, and respondents' perception of the health system's performance. The Portuguese instrument was finalized in three dimensions of analysis and 106 questions, involving the process of care in the healthcare unit, the local implementation of national policy guidelines, and the interviewees' perception of the performance of the healthcare system with regard to the approach to overweight.

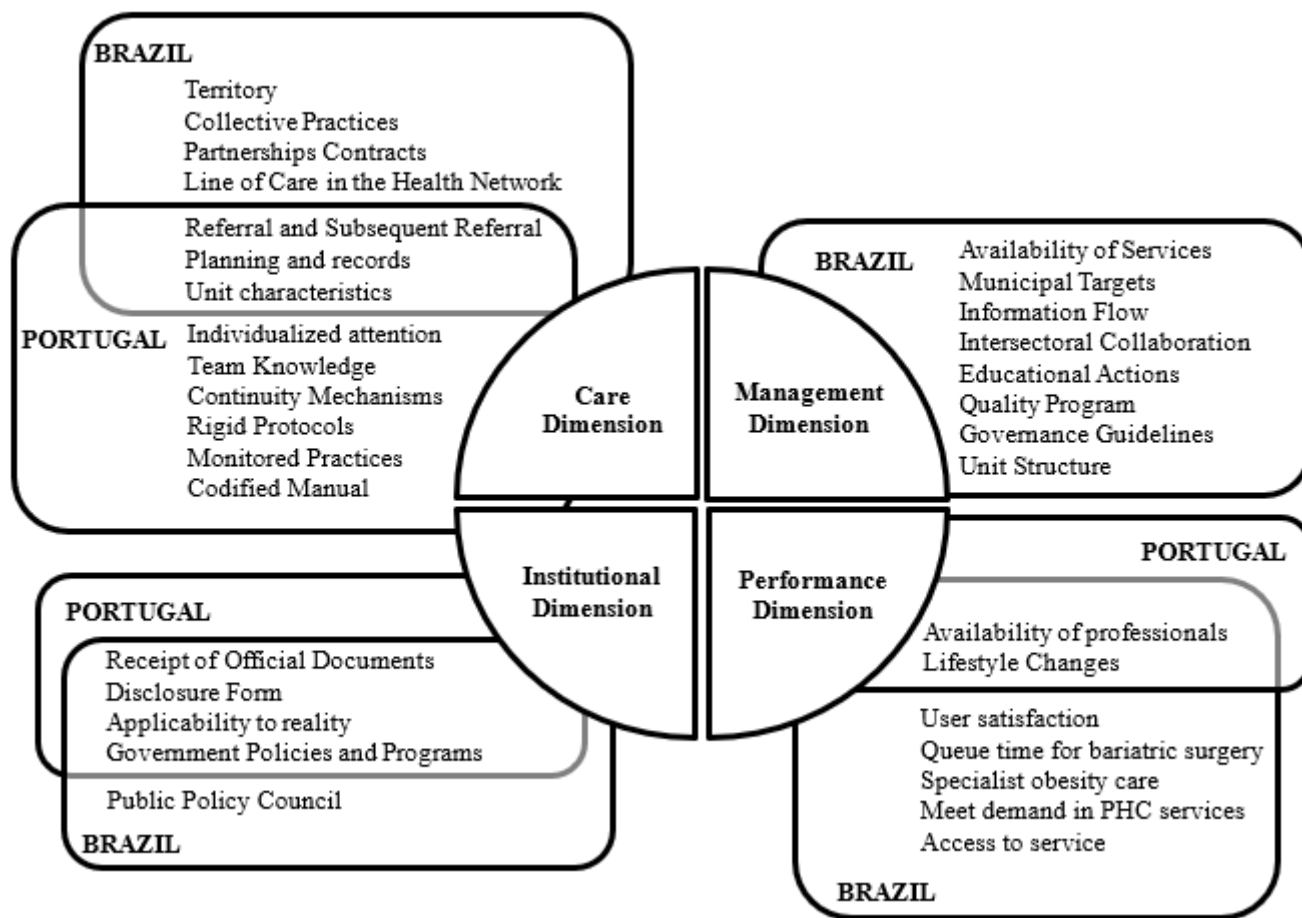
**Table 1** - Dimensions and number of analysis questions for primary care for overweight individuals in Brazil and Portugal, according to the consensus of national experts.

Analysis Dimensions	Number of Questions	
	Brazil	Portugal
	Managers and professionals	Managers and professionals
<i>1: Organization of PHC</i>	102	76
<i>2: PHC Management</i>	52	0
<i>3: Implementation of public policy for overweight individuals</i>	14	10
<i>4: Health System Performance</i>	41	20
<b>Total Criteria</b>	<b>209</b>	<b>106</b>

Source: Created by author.

The divergence regarding the priority criteria is clear, mainly related to what information Brazilian and Portuguese managers and/or health professionals are expected to know, which resulted in a significant difference in the total number of questions between instruments. A comparison between the criteria that grouped the sets of questions for each dimension (construct) present in both instruments is shown in Figure 1. The first dimension of analysis revealed a high level of divergence in the organization of the care process in the healthcare unit. In Brazil, it is important to ask the health unit manager about the number of users, population, patients served, bariatric surgery waiting list, and reasons for seeking healthcare. In Portugal, these questions are unnecessary because the healthcare information system readily provides the data.

**Figure 1** - Convergences and divergences in the categories of analysis criterion for primary care for overweight individuals in Brazil and Portugal, according to consensus of national experts. 2021.



Source: Created by author.

Linguistic issues were also present, with Portuguese experts being much more demanding about the precision of the terms used. The terminology for the classification of obesity launched a series of discussions on what seemed clear to Brazilians. It's important for Portuguese experts to explain how overweight and obesity are categorized based on BMI to avoid any confusion when using this measurement.

The level of attention, even in PHC, presented the main divergence in focus between the two countries. In the Portuguese system, they prioritize care at the individual level, whereas in the Brazilian system, the focus is on the collective level. Mapping the territory and its elements are important for Brazilian experts. They focus on using this information and studying the frequency and intensity of space and staff usage. For Portuguese experts, although this information exists and is systematized, unit managers are not expected to know and interact with these spaces. Portuguese experts did not find questions about the health team's participation in community gardens relevant. As a result, we excluded these from the instrument.

Nevertheless, it was important to identify exercise infrastructure availability for the instruments in both countries. To distinguish between them, in Brazil, it is crucial to be familiar with the spaces used or recommended, such as public swimming pools for hydro gymnastics, parks or bike lanes. Portuguese experts just need to know if the team advises users, regardless of their clinical infrastructure situation.

For Brazilian experts, in the first dimension, sub-item Collective Practices, the assessment of the existence and clarity of a unit's mission and work plan was important. Portuguese experts would already be well versed in this information so it was

excluded from their instrument. For the same reason, Portuguese experts did not consider useful the permanence of the evaluation criteria in primary health care (PHC), processes of referral to specialized services, referral and counter-referral in the follow-up of patients treated at other levels of care, protocols for comprehensive care, or participation in a quality improvement program. However, both countries found questions about the work plan details, topic inclusion, food and nutrition guidelines, and prevention of overweight and obesity care to be relevant.

Issues related to the provision of nutritional assistance differed in scope between countries. In Brazil, this service can be offered in the unit itself by professionals from the Expanded Center for Family Health and Primary Care or seconded from another service. In contrast, Portugal organizes PHC into health center groups. Each has multiple family health units with primary care doctors and nurses, along with a shared care resource unit that includes nutritionists, psychologists, social workers and other health professionals. When primary care physicians see the need for nutritional therapy, they refer the patient to a nutritionist/dietitian.

When comparing the suggestions of Brazilian and Portuguese experts regarding the instrument, it was also observed that pragmatism was added to Portuguese questions. In Brazil, they included more delimited and divided questions, such as three questions to assess whether the units have a clinical protocol for attention to overweight and obesity and/or unique therapeutic projects. If the team adopted them and if they constituted an integral approach, they were considered adequate and essential. For Portugal, grouping them into a single question was more appropriate. The same occurred for the question that evaluated the unit's partnerships for care of obese adult users. It was considered essential for Brazilians to answer individually in cases of partnerships with state networks and agencies, municipal networks and agencies, and non-governmental organizations, among others. In Portugal, experts considered that this set of questions should be applied more generally because they considered it more important to know if there was a partnership than to identify with whom it was done.

In Brazil, the second dimension examines the role of municipal management in ensuring good working conditions in health units. This dimension deals with coordinating work conditions, information flow and resource availability for work development and referral to other healthcare services. Brazilian experts judged all included questions as relevant. However, Portuguese experts had a different opinion as they believed most issues in this area were repetitive or obvious due to administrative processes within the countries.

Amongst the questions deemed irrelevant to the Portuguese experts are those which comprise the entirety of the Second Dimension, Management. Matters related to command and control, management feedback, communication to and from bariatric and specialized service, quality assurance, governance reporting and more are obvious and not in need of questioning or examination. Also considered obvious were issues related to assessing access to information at the state and national levels and whether preventive maintenance of equipment and infrastructure is made available. All these were excluded from the Portuguese instrument.

Questions about the line of care for overweight and obesity and vacancies in specialties like nutrition, physiotherapy, and psychology were similarly considered repetitive. As a result, these questions were also withdrawn, with the reasoning that service level management furnished directly by the unit, manages resources itself.

Unlike in the first round of the expert panel in Portugal, in the second round, when dimension 2 was excluded from the instrument, some questions were considered relevant to the teams in Portugal. Among them were questions related to the opportunities promoted by the management of health teams to present work in the field of overweight prevention and obesity management at local, regional and national events on continuing education, and those related to the quality of infrastructure and resources available at the unit.

The implementation of public obesity policies was addressed in the third dimension of the Brazilian instrument and the second dimension in Portuguese. Instruments from both countries included questions about the formal receipt of official

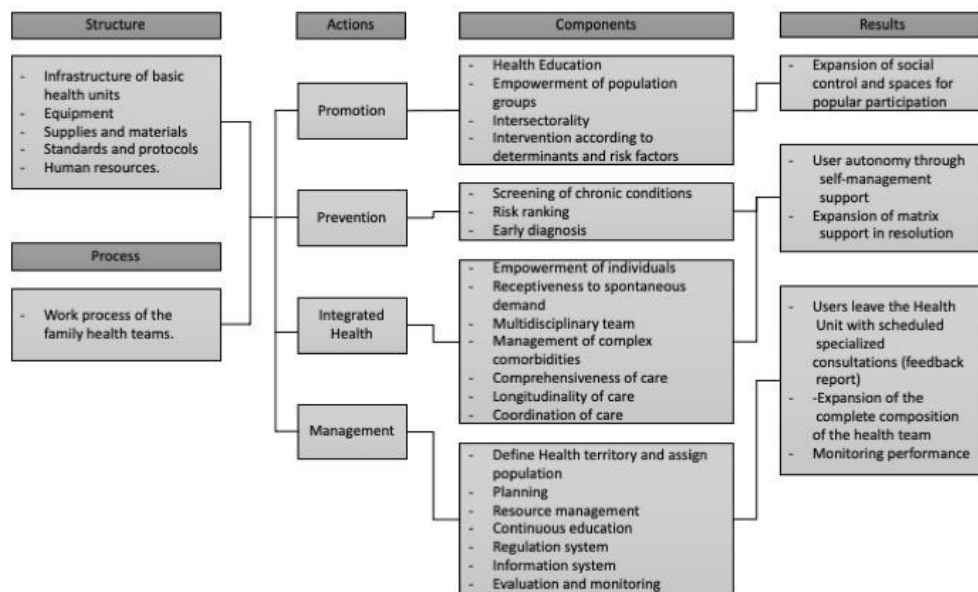


documents and how they were applied to the reality of the health unit, varying only in documents specific to each country. In addition, they both question opinions about the adequacy of policies for the prevention of overweight and obesity management relative to the reality in which the unit is located, with regard to their planning and implementation. Moreover, in both instruments, it was considered important to include open questions to assess the qualitative opinions of professionals regarding the existence of public policies (government projects and programs) in the community to prevent overweight and manage obesity, and whether existing policies are planned and implemented adequately for the geographical location served.

The last dimension examines health system performance criteria. Most of the proposed questions were adjusted to the reality in Portugal and grouped together for greater clarity. As they did not apply to the unique characteristics of either country, questions related to reception or satisfaction of demands (such as collecting pressure measurements and consultations with specialists) were removed from the Portuguese form. Among the questions included in the Brazilian instrument are those that aim to identify whether the units were able to meet the demands for collective and community-oriented activities, such as group walks or other physical activities, home visits and communication with other sectors from the Web.

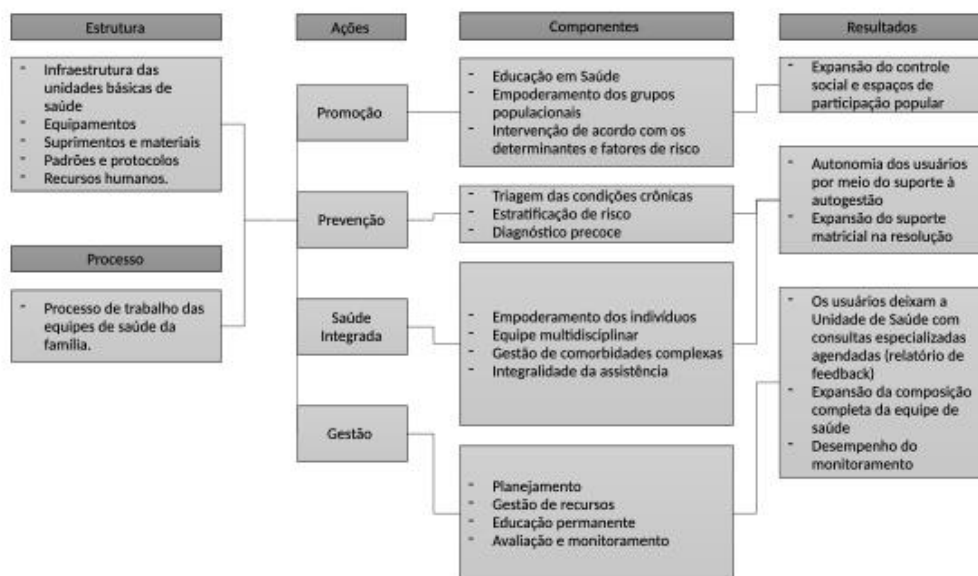
Based on the validity of the criteria, theoretical logical models were organized for health policies in Brazil and Portugal (Figures 2 and 3, respectively) and adapted from the model proposed by Alves (2019).

**Figure 2** - Proposed theoretical logical model for primary care for overweight in **Brazil**.



Source: Created by the Author. Adapted from Alves (2019).

**Figure 3** - Proposed theoretical logical model for primary care for overweight in **Portugal**.



Source: Created by the Author. Adapted from Alves (2019).

The criteria validated by Brazilian experts included all the components of the Brazilian theoretical logical model (Figure 2). The Portuguese model (Figure 3) does not contain the same number of components; however, both converge to the desired result.

#### 4. Discussion

According to the WHO, the characteristics of PHC are universal coverage and access; first point of contact; comprehensive, integrated, and continuous care; family and community guidance; emphasis on health promotion and disease prevention; appropriate attention; active participation mechanisms; strong political, legal, and institutional frameworks; equitable policies and programs; optimally tuned organization and management structures; appropriate human resources; adequate and sustainable resources; and intersectoral actions (Pan American Health Organization, 2007). The Brazilian experts aligned with these guidelines.

Both Brazil and Portugal have similarities in their healthcare models as they strive to align with WHO characteristics of PHC and criteria. In Portugal, experts prioritize individuals, while in Brazil, the focus is on integrated care and collective action within specific territories. Indeed, the instrument of analysis used to assess measures to combat overweight in Brazil included four dimensions, one of which was completely eliminated for Portugal because it did not fit the reality of the country. In both countries the instrument included the integration of care in the health unit, local implementation of national policy guidelines, and interviewees' perceptions of health system performance. In Brazil, the instrument also integrates care at the municipal level.

Notably, however, the criteria validated by Brazilian experts may, in fact, express more what they have found in recent guidelines for overweight and obesity rather than what they actually found in the services. This may be attributed to the fact that these experts are involved in the development of guidelines that are not yet implemented. According to Brazilian



guidelines, the expectation is that PHC will alleviate the overwhelming demand on specialized care (Chávez, Rennó and Viegas, 2020).

The implementation of the Family Health Strategy in four major Brazilian centers in 2008 is being evaluated, consolidating experts' experiences on health model reorganization. However, its reorganization is still pending (Almeida et al., 2011). This helps us to understand why the criteria agreed upon by Brazilian experts are aligned with the logical theoretical model of the system. Since the Brazilian health model is in the process of change and the experts are aware of the probable end-state, this may have led these experts to include this information in the approved criteria. The LTM was developed along Alma Ata guidelines (World Health Organization, 1978) and incorporates international consensus on PHC innovation, such as the Adelaide Declaration (World Health Organization, 2010) and others. Thus, Brazilian experts are cognizant of national policy guidelines. Nonetheless, the guideline creators were also aware of the limitations resulting from Brazil's very large size in ensuring universal quality in health services. In that regard, the approach to overweight in PHC is still in its early stages in CSP (Cuidade da Saude Primeiro - Portugal) (Burlandy et al., 2020). This may explain the higher number of plausible evaluation criteria among Brazilians, as they seek to implement national policy and affect the conditions for this to occur. In Portugal, certain practices and structures may have such high codification that they may not cause the same concern. An instrument should have clear objectives. In Brazil, the process of setting criteria was also linked to measuring how recent guidelines were incorporated, which may have influenced decisions and potentially complicated the objective.

Portugal satisfies the EU's requirements for effective and efficient health services. The practical nature of the results found among the Portuguese experts may be attributed to this requirement. Practicality can also be found in Portuguese guidance documents with clearly defined attributions, guidance manuals, and integrated assistance plans (Portugal, 2016). The work in the PHC in Portugal is sectoral, to the point that the managers of the health center groupings indicate that only nutritionists or specific sectors would be able to answer certain questions. Some nutritionists are hesitant to talk about their services or the involvement of other professionals in addressing overweight. The health structure of the country allows for and favors individual care. Collective approaches occur, but are described in other policies that cover collective environments, food supply and consumption regulation. However, they do not extend to local health units, which are instead called for by service-level contracts (Monteiro et al., 2017).

In Portugal, another relevant aspect is that separate documents and sectors of the service address pre-obesity (25 Kg/m<sup>2</sup> BMI<30 Kg/m<sup>2</sup>) and obesity (BMI 30 kg/m<sup>2</sup>). PHC services are expected to emphasize individualized pre-obesity care (Portugal, 2016), although they also provide obesity care up to grade-2 without complications. In Brazil, PHC units are expected to requisition services and support of multiple services, including obesity care and monitor users receiving specialized care (Brazil, 2013a). In this situation, resources are limited and in turn reduce resources and relax criteria for the transfer of individuals between services. One such example is municipalities must organize their overweight and obesity care lines to support transfers for complex bariatric surgeries, which further strain resources.

In Brazil, a forceful presence of popular movements has marked the struggle to ensure the right to health. Health conferences at all government levels have bolstered the idea of health as a right through popular participation. However, although the TLM of the PHC is consolidated in an ideal situation, it is difficult to ensure end-to-end service (Almeida et al., 2011) and many challenges still exist, preventing the universality of coverage. Therefore, competition for priorities within the health system has arisen. Within the country, policies for care, especially for obesity, are relatively new and have not been prioritized in the SUS. In PHC units, healthy lifestyle habits, including dietary practices, have been promoted and emphasized in the national guidelines. However, there has been a large increase in surgeries for obesity, which has caused the biggest bottleneck for access to specialized services to assist individuals suffering from obesity and its complications. Those who need specialized care, often individualized care, have not received the required attention, although in theory, its provision is

expected from PHC. This is because the country lacks sufficient services to offer specialized assistance from endocrinologists, psychologists, psychiatrists, nutritionists, and physiotherapists amongst others. (Aguilera et al., 2013; Silva et al., 2017)

In Portugal, by contrast, the increase of health policy has matched the increase in the prevalence of obesity. The decision to prioritize the problem came after the country became a signatory to the European Charter for Fight Against Obesity. (Beja et al., 2014) This is why the Portuguese health system has well-established paths for addressing overweight care, which are aligned with the demand.

Despite these differences, the universal health models adopted by the two countries have many similarities, yet each country can learn a lot from the other. (Soranz and Pisco, 2017; Carrapiço et al., 2017; Lapão et al., 2017; Monteiro et al. 2017) A comparative study of the PHC of Rio de Janeiro in Brazil and the Lisbon region of Portugal, showed that Portuguese services are comprehensively delivered, while characterizing those in Brazil as selective. Despite their differences, Portuguese and Brazilian managers have similar ideas on organizing care, teamwork, communication, training, facilities, equipment, computerization, payment for performance, resource procurement and political leadership. (Soranz and Pisco, 2017; Carrapiço et al., 2017)

This study has a limitation in that it only reflects the perception of experts, which plays a crucial role in characterizing the model conceived in each country and how it is expressed in the evaluations of researchers and technicians. However, this is lacking breadth. In a subsequent step, other actors, perhaps families, users and community members, must be involved to get a broader perspective on what we must evaluate and even the purposes of the evaluation. Using better assessment approaches will improve service effectiveness and process indicators, especially in Brazil.

## 5. Conclusion

Understanding health care between any two nations is complex and not to be undertaken naively. Seemingly similar countries and healthcare professionals possess similar but not identical notions about fundamentals, inevitably resulting in differences in delivery. Certainly, some differences result from the sheer disparities of scale between nations. Geography and population size are likely to affect policies, particularly in Brazil.

Experts in both Brazil and Portugal converge substantially on matters of the process of validation for the construct and criteria of a diagnostic tool for obesity care. However, they diverge notably in the management and performance dimensions. Portugal emphasizes individualized service, while Brazil prioritizes a stronger management process for service delivery.

Though revealing about convergences and divergences of process validation for obesity care, the analysis conducted here demands further investigation with a broader scope of participants, including users of primary health care.

Future planned research intends to understand and benchmark how both Brazil's and Portugal's healthcare policies align with WHO guidelines in terms of health priorities, universal access and sustainable development goals. Motivation behind this choice is to find relative performance compared to a global objective and at the same time illustrate potential blindspots in governance and financing that could be aided by this study.

## Declarations

Ethical Compliance: No procedures were performed on humans nor animals. The research was conducted in accordance with the ethical standards of the institutional and national research committee and the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Conflict of Interest: The authors declare that they have no conflicts of interest regarding the subject matter or materials discussed in this manuscript.

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## Authors' Contributions

Luciane Costa and Maria Rita de Oliveira contributed to the conception and design. Luciane Costa, Adriana Aparecida de Oliveira Barbosa, Débora Isabel Fernandes Cláudio and Teresa Alexandra Oliveira Rodrigues contributed to data Acquisition. Luciane Costa, Maria Rita de Oliveira and Adriana Aparecida de Oliveira Barbosa contributed to data analysis and interpretation. Luciane Costa, Adriana Aparecida de Oliveira Barbosa and Maria Rita de Oliveira helped in drafting this paper. Luciane Costa, Isabel Monteiro, Flora Correia and Maria Rita de Oliveira contributed to the critical revision of the intellectual content. Flora Correia and Maria Rita de Oliveira supervised the study.

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