

Psychosocial and Economic Influences on Access to Bariatric Surgery in the Public Health System

Influências Psicossociais e Econômicas no Acesso à Cirurgia Bariátrica na Rede Pública de Saúde
Influencias Psicosociales y Económicas en el Acceso a la Cirugía Bariátrica en la Red Pública de Salud

RESUMO

Objetivo: Analisar como os determinantes sociais, econômicos e psicológicos influenciam o acesso à cirurgia bariátrica no Sistema Único de Saúde (SUS) na cidade de Manaus-AM. **Método:** Estudo qualitativo de caráter descritivo, com base em revisão narrativa da literatura e observação participante realizada em unidade básica de saúde e ambulatório especializado no período de maio a julho de 2025, correlacionando dados teóricos e práticos, obtidos nas visitas e diálogos com os profissionais de saúde de cada estabelecimento abarcado pelo estudo. **Resultado:** Verificou-se que fatores como baixa renda, escolaridade limitada, dificuldades de deslocamento, estigma da obesidade e falta de preparo técnico das equipes impactam negativamente a adesão ao tratamento e a continuidade do cuidado. A ausência de ações educativas e falhas na articulação entre níveis de atenção agravam o cenário. **Conclusão:** A obesidade é agravada por barreiras estruturais e psicossociais. A superação dessas limitações demanda políticas públicas integradas, educação em saúde e fortalecimento dos diversos níveis de atenção à saúde. **DESCRIPTORIOS:** Obesidade; Cirurgia bariátrica; Sistema Único de Saúde; Determinantes sociais da saúde; Atenção primária à saúde.

ABSTRACT

Objective: To analyze how social, economic, and psychological determinants influence access to bariatric surgery in the Brazilian Unified Health System (SUS) in the city of Manaus-AM. **Method:** A qualitative descriptive study based on a narrative literature review and participant observation conducted in a primary healthcare unit and a specialized outpatient clinic, correlating theoretical and practical data. **Results:** Factors such as low income, limited education, transportation difficulties, obesity-related stigma, and lack of professional training negatively impact treatment adherence and continuity of care. The absence of educational actions and gaps in coordination among levels of care worsen the situation. **Conclusion:** Obesity is aggravated by structural and psychosocial barriers. Overcoming these limitations requires integrated public policies, health education, and strengthening of primary care. **DESCRIPTORS:** Obesity; Bariatric surgery; Unified Health System; Social determinants of health; Primary health care.

RESUMEN

Objetivo: Analizar cómo los determinantes sociales, económicos y psicológicos influyen en el acceso a la cirugía bariátrica en el Sistema Único de Salud (SUS) en la ciudad de Manaus-AM. **Método:** Estudio cualitativo descriptivo, basado en revisión narrativa de la literatura y observación participante en una unidad de atención primaria y un ambulatorio especializado, correlacionando datos teóricos y prácticos. **Resultados:** Factores como baja renta, educación limitada, dificultades de transporte, estigmatización relacionada con la obesidad y falta de capacitación profesional impactan negativamente en la adherencia al tratamiento y en la continuidad del cuidado. La ausencia de acciones educativas y fallas en la articulación entre niveles asistenciales agravan el cuadro. **Conclusión:** La obesidad se ve agravada por barreras estructurales y psicosociales. Superar estas limitaciones requiere políticas públicas integradas, educación en salud y fortalecimiento de la atención primaria. **DESCRIPTORIOS:** Obesidad; Cirugía bariátrica; Sistema Único de Salud; determinantes sociales de la salud; Atención primaria de salud.

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ID Caio Rodrigo Reis dos Santos
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0004-5257-7140>

ID Ana Carolina Marques da Costa
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0006-0449-7079>

ID Júlio César Neves Dantas
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0004-8617-3240>

ID Iane de Araújo Mota
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0003-2398-4591>

ID Ana Beatriz Mendes Coelho
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0002-4542-9479>

ID Isadora Lúcia Queiroz Herculano
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0008-4901-9374>

ID Luana Victoria dos Santos Fernandes
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0007-2928-5256>

ID Thierry Sander Coelho dos Reis
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0001-2958-2732>

ID Julia Evan Mendes Perez
Undergraduate student in medicine. Federal University of Amazonas.
ORCID: <https://orcid.org/0009-0008-7064-1272>

ID Luiz Henrique Gonçalves Maciel
Master's Degree in Tropical and Infectious Diseases, Amazonas State University. Professor, Department of Public Health, Federal University of Amazonas.
ORCID: <https://orcid.org/0000-0002-1625-8255>

ID Fabiana Mânica Martins
PhD in Environmental Sciences and Sustainability in the Amazon, Federal University of Amazonas. Professor in the Department of Public Health, Federal University of Amazonas.
ORCID: <https://orcid.org/0000-0002-4440-2680>

ID Jucyette da Silva Gomes Evaristo
Master's Degree in Health Sciences, Federal University of Amazonas. Professor in the Department of Public Health, Federal University of Amazonas
ORCID: <https://orcid.org/0009-0003-6935-9652>

ID Celsa da Silva Moura Souza
Doctorate in Evidence-Based Health, Federal University of São Paulo. Professor, Department of Public Health, Federal University of Amazonas.
ORCID: <https://orcid.org/0000-0002-1669-1462>

INTRODUCTION

Obesity is defined by the World Health Organization (WHO) as the abnormal or excessive accumulation of body fat, capable of compromising health and increasing the risk of chronic diseases. It is a

multifactorial condition, influenced by genetic, behavioral, socioeconomic, and environmental determinants, which makes its clinical and preventive management particularly challenging. Since 1975, its global prevalence has tripled, reaching more than 650 million adults, constituting

an epidemic with a major impact on public health²⁻⁴. It is considered one of the main risk factors for cardiovascular disease, type 2 diabetes, dyslipidemia, sleep apnea, and certain types of cancer^{1,2}.

In Brazil, the growth of obesity has been significant. More than half

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of the adult population is overweight, and approximately 20% are already classified as obese^{3,4}. Between 2006 and 2019, the prevalence of obesity nearly doubled, disproportionately affecting women, black people, and low-income populations⁴. The increase is also significant among children and adolescents, contributing to the expansion of the burden of chronic diseases and raising healthcare costs within the Unified Health System (SUS)^{4,5}.

Obesity care in the SUS is organized into three levels. Primary Health Care (PHC) is responsible for screening, prevention, and initial treatment of cases, with educational and nutritional measures and incentives for physical activity⁵. Cases with greater clinical complexity are referred to secondary and tertiary levels, where bariatric surgery may be indicated, according to criteria established in ministerial ordinances⁶. However, the availability of surgery is still limited and concentrated in certain regions: in 2018, five Brazilian states, including Amazonas, did not have centers accredited by the SUS to perform the procedure⁷. This territorial disparity compromises the Amazonian population's access to surgical treatment for obesity and reinforces historical inequalities in health⁷. Although there are effective care guidelines and technologies for managing obesity, clinical treatment dropout rates remain high, ranging from 40% to 50% of patients^{8,9}. Among those seeking bariatric surgery, the journey is marked by institutional barriers, rigorous technical requirements, and socioeconomic obstacles that hinder effective access, especially in contexts of greater vulnerability^{3,7}.

In this context, this study proposes to analyze how social, economic, and psychological factors interfere with access to bariatric surgery in the public health system, focusing on the Amazon region. This is a ter-

ritory marked by great geographical distances, weaknesses in health infrastructure, and barriers to access that amplify the effects of social determinants of health. Understanding these barriers is essential to support public policies and care strategies that promote greater equity and better health outcomes for people with obesity in the Amazon.

METHOD

This is a qualitative study, structured in the form of an experience report, developed in the context of the Public Health II course of the Medicine program at the Federal University of Amazonas.

The activities were carried out between May 2025 and July 2025, with technical visits and participation in lectures at health institutions at three levels of care: primary, secondary (medium complexity), and tertiary (high complexity). The locations included the Japiim Basic Health Unit, the PET-Saúde Equidelas project, the Southern Health District, CONSEA, the Municipal Health Secretariat (SEMSA), and the Araújo Lima Outpatient Clinic.

During the visits, data were collected using a semi-structured questionnaire developed by the authors, containing open and closed questions based on the study's guiding question: *"How do social, economic, and psychological aspects influence access to bariatric surgery in the public health system in the Amazon?"* The research did not require an ethics committee due to the methodology of experience reporting and the eminently impersonal nature of the questions asked, which addressed, in an integrated manner, aspects related to the organization of services and the physical structure of the units visited; the functioning of multidisciplinary teams and referral flows for specialized care; the main socioeconomic barriers faced by us-

ers in adhering to obesity treatment; the impacts of emotional and psychological factors on the therapeutic journey; and the perception of professionals regarding the effectiveness of the obesity care line and the comprehensiveness of care.

The questions were directed to the health professionals present at the locations visited—including physicians, nutritionists, nurses, and community health workers—and were asked orally. The answers were recorded in writing in a field diary and, when authorized by the participants, also recorded on audio for later transcription and analysis. The data obtained were examined through qualitative analysis, based on Technical Note No. 008/2024 – NUDRON/GECC/DAP/SUBGS/SEMSA, which organizes the management of patients with obesity in the Unified Health System (SUS), with a focus on thematic content analysis, seeking to identify recurrences, divergences, and discursive patterns on the social determinants of health and access to surgical treatment for obesity.

RESULTS

Between May 2025 and July 2025, technical visits and participation in lectures were carried out with the aim of observing health care in the context of obesity. The activities sought to understand how Primary Care functions as a gateway for patients with obesity, identify barriers to access to specialized care, and analyze the influence of social determinants on treatment adherence and the effectiveness of the services offered. It was observed that the structural fragility of the network, coupled with the lack of coordination between levels of care and the absence of adequate psychosocial support, directly compromises adherence to clinical treatment and bariatric surgery as a therapeutic outcome.

The findings reveal that long waiting times, lack of laboratory tests, and limited specialized referrals hinder continuity of care. Emotional issues,

socioeconomic status, and geographic barriers also discourage patients from remaining in the care pathway. The following tables present a summary of

the activities carried out during each visit and a comparison between institutional guidelines and what was observed in the field:

Table 1. Summary of visits and lectures held, with location, date, methodology used, and objectives of each activity

Location of visit/lecture	Date	Methodology used	Objective
1. Japiim UBS	May 21, 2024	Visit with a list of questions for professionals	Observe obesity management in PHC and the role of the multidisciplinary team
2. PET-Health (Equidelas)	May 14, 2025	Participation in thematic seminar	Analyze geographical and social barriers to accessing healthcare
3. Southern Health District	May 23, 2025	Institutional visit with lectures	Seek data on territorial actions related to obesity
4. CONSEA	June 11, 2025	Classroom lecture on Food and Nutritional Security	Relate FNS to obesity prevention strategies
5. SEMSA (with ACS)	June 18, 2024	Lecture with community health agents	Understanding the care flow and challenges of the municipal network
6. Araújo Lima Outpatient Clinic	July 2, 2025	Observation of stoma therapy consultations	Analyzing socioeconomic and structural aspects in wound treatment and possible links to obesity

Source: Own work.

Table 2. Perspectives and Results of the Observational Visit

Theoretical Perspective (Guidelines)	Observed Result (Technical Visits)
Structured PHC with screening, therapeutic plan, and multidisciplinary team.	PHC without laboratory tests, with limited pharmacy services and no educational groups.
Specialized referrals with defined and agile flows.	Prolonged waiting via SISREG; patients give up on the process.
Offer of educational groups and systematic nutritional monitoring.	No structured groups; limited nutritional monitoring.
Psychosocial support guaranteed at all levels of care.	Lack of ongoing psychological assistance.
Consideration of DSS in the therapeutic plan.	DSS recognized, but poorly incorporated into clinical practice.
Coordinated network for preparation and performance of bariatric surgery.	No accredited centers in the region until 2018; fragmented preparation.

Source: Own work.

This analysis shows that, although there are normative protocols for the management of obesity, the effective application of these flows is still compromised by structural, logistical, and care failures. Adherence to bariatric surgery depends on a long and complex care pathway, which, in practice, is interrupted by network limitations and the lack of comprehensive support for patients with obesity.

I. Japiim Basic Health Unit

The visit to the Japiim Basic Health Unit on May 21, 2025, focused on the practical analysis of the obesity care pathway at the primary level. The professionals responsible for providing explanations and follow-up were a nurse and a nutritionist who work at the facility. They contributed the following information: screening is based on qualified listening, weighing, height measurement, and referral to a general practitioner. Medical care includes medical history, requesting laboratory tests (not available at the

unit), and, when necessary, referral via SISREG to a nutritionist, usually at another unit. Direct referrals to endocrinologists are not feasible, with an average wait of six months to a year and a half. The unit has a multidisciplinary team (e-Multi), with a physical therapist and physical educator called in for specific situations. As a complementary strategy, the physician may recommend the use of community spaces for physical activity. Reports from the nutritionist indicate that adherence to treatment depends more

on the patient's emotional disposition than on economic factors. Patients with greater personal commitment have better outcomes.

There are no educational groups focused on obesity. Nutritional monitoring exists, but there is no systematic data on its effectiveness. The lack of tests, limited pharmacy services, and difficulty in accessing specialists compromise comprehensive care. No continuing education initiatives focused on obesity were identified among the unit's professionals.

II. PET-Health Equidelas

The seminar held on May 14, 2025 highlighted how social determinants affect access to basic health services, through lectures presented by psychology students. Reports were presented on communities with a shortage of professionals, exclusive dependence on community agents, and low adherence to telehealth. In remote locations, the feasibility of accessing services depends on economic conditions or the evolution of the clinical picture. The activity reinforced the influence of geographical and social factors on the effectiveness of health care.

III. Southern Health District

During the institutional visit, it was not possible to obtain specific information on the obesity care line, as the data was attributed to another sector not present at the time.

IV. CONSEA

The lecture by the National Council for Food and Nutritional Security (CONSEA), conducted by two nutritionists, was held on June 11, 2025, and addressed the link between Food and Nutritional Security (SAN) and obesity prevention. FSN was presented as a human right and as the basis for the formulation of public policies that promote adequate and healthy eating. CONSEA's work seeks to integrate

intersectoral actions to ensure access to quality food and health-promoting environments. The content covered highlighted the relevance of FSN in promoting health and reducing inequalities associated with obesity.

V. SEMSA

The lecture held on June 18, 2025, promoted by two SEMSA community agents, addressed the care flow for patients with obesity in the SUS. The practices adopted by family health teams, difficulties in accessing specialists, and limitations in the care of endocrine disorders associated with obesity were discussed. The shortage of endocrinologists, geographical barriers, and poor transportation make therapeutic follow-up difficult, especially among vulnerable populations.

The fragility of psychological care, which is still limited in UBSs, was also highlighted. Professional training occurs sporadically and does not systematically address topics such as obesity and social determinants. Technical Note No. 008/2024 provides guidance on care based on BMI, but actions remain insufficient given the overload of the network. The absence of accredited centers in Amazonas until 2018 reflects territorial inequality. Ideal preoperative preparation remains restricted and inaccessible.

VI. Araújo Lima Outpatient Clinic

The technical visit carried out on July 2, 2025, at the Araújo Lima Outpatient Clinic focused on observing stoma therapy care. The cases monitored, conducted by a nurse working at the site, were not related to bariatric surgery, but allowed us to observe the influence of socioeconomic factors on treatment adherence. One of the patients reported that his ability to maintain clinical follow-up was directly related to his workload. Another patient, with a complex surgical wound, received part of their care at the UBS and part at the outpatient

clinic, revealing gaps in the integration of the network. The nurse in charge highlighted the absence of bariatric patients in the SUS at that unit. The follow-up of cases in the private sector includes remote support and specialized dressings, resources that are not yet widely available in the public service.

DISCUSSION

For the discussion of the findings, Technical Note No. 008/2024 – NUDRON/GECC/DAP/SUBGS/SEMSA was used as the main reference, which organizes the management of patients with obesity in the Unified Health System (SUS), according to the degree of obesity identified. This regulation is represented in Flowchart 1, which structures the care of overweight and obese adult users at different stages of the care pathway.

Bariatric surgery is a highly complex procedure reserved for severe cases of obesity, after attempting a clinical approach and rigorous multidisciplinary assessment. This complexity involves not only physiological aspects, but also social and psychological aspects, requiring coordination between different levels of health care. The data from this study showed that the effectiveness of the care pathway is compromised by structural factors in the healthcare network, limitations in access to specialists, and a lack of continuous patient support.

One of the main elements that impact access to care and adherence to surgical treatment are the social determinants of health (SDH), especially socioeconomic and psychological conditions. Baez et al. highlight that these determinants not only influence the prevalence of obesity, but also interfere with the prognosis and therapeutic follow-up of patients¹.

Flowchart 1. Care for overweight and obese adult users.



Source: MANAUS (Municipality). Municipal Health Secretariat. *Technical Note No. 008/2024 – NUDRON/GECC/DAP/SUBGS/SEMSA: Work process of health units in caring for users with altered BMI*. Manaus: SEMSA, May 24, 2024.

I. Socioeconomic Status

The literature shows that income, housing, and education directly affect the risk of developing obesity. In high-income countries, people in vulnerable situations have higher rates of obesity, while in low-income countries, obesity can coexist with malnutrition, especially in areas where there is food insecurity. Education influences the formation of healthy habits, with individuals with lower levels of education having a higher prevalence of overweight and obesity^{3,4}. Environmental factors such as the lack of safe public spaces for physical activity and high rates of violence contribute to a sedentary lifestyle, especially in peripheral urban contexts^{10,6}. These factors also affect access to public health services, particularly those that are more complex, such as bariatric surgery^{5,10,8}. Financial instability and low purchasing power are associated with difficulties in adherence, treatment abandonment, and food

insecurity, as already evidenced in the literature⁹. In Manaus, HIPERDIA data reveal a high prevalence of obesity (27%) and overweight (65.2%)²⁰. At the same time, primary care services remain insufficiently structured to meet the growing demand, with a shortage of laboratory tests, specialist professionals, and regular educational activities^{5,6}. This discrepancy between demand and installed capacity compromises the effectiveness of care.

II. Psychological Condition

Psychological factors also impact treatment adherence, even when socioeconomic conditions are minimally adequate. Chronic stress, anxiety, and adverse childhood experiences are associated with obesity—through mechanisms of emotional regulation and activation of the hypothalamic-pituitary-adrenal axis, which promotes unregulated food consumption and compulsive eating⁹. Loneliness, discrimination, and social stigmatization also hinder engagement in self-care practices, negatively affecting treatment success and the maintenance of bariatric surgery results^{3,9,16}. The literature recommends integrated approaches that consider emotion-

al and social aspects as part of the therapeutic plan. However, psychological care was found to be absent or fragmented in the units visited. Professionals reported difficulty in monitoring patients with psychological distress, indicating the need to expand multidisciplinary teams.

III. Feedback between DSSs and Obesity

Obesity can both be caused by social determinants and aggravate them, creating a positive feedback loop. Barriers to accessing health services—combined with social exclusion—reinforce cycles of vulnerability and make it difficult to reverse the clinical picture. The literature suggests that educational strategies can mitigate these cycles by promoting empowerment and combating institutionalized fatphobia. In the field, a lack of educational actions aimed at users and continuing education for professionals was identified. Such gaps hinder the development of humanized and technical approaches and reinforce inappropriate practices. Continuing education is identified as an essential strategy for improving care and reducing prejudices that negatively impact treatment adherence.

IV. Practical Comparisons with the Literature

The comparison between theory and observed reality revealed significant discrepancies. The waiting time for specialist referral was reported to be longer than six months—contrary to the recommendations of Technical Note No. 008/2024, which proposes quarterly follow-ups^{6,18}. This delay compromises continuity of care, which is reflected in patient dropout rates. The absence of educational groups and clear flows of specialized care were identified as critical barriers, in disagreement with the recommendations of the Ministry of Health guidelines⁵. In particular, coordina-

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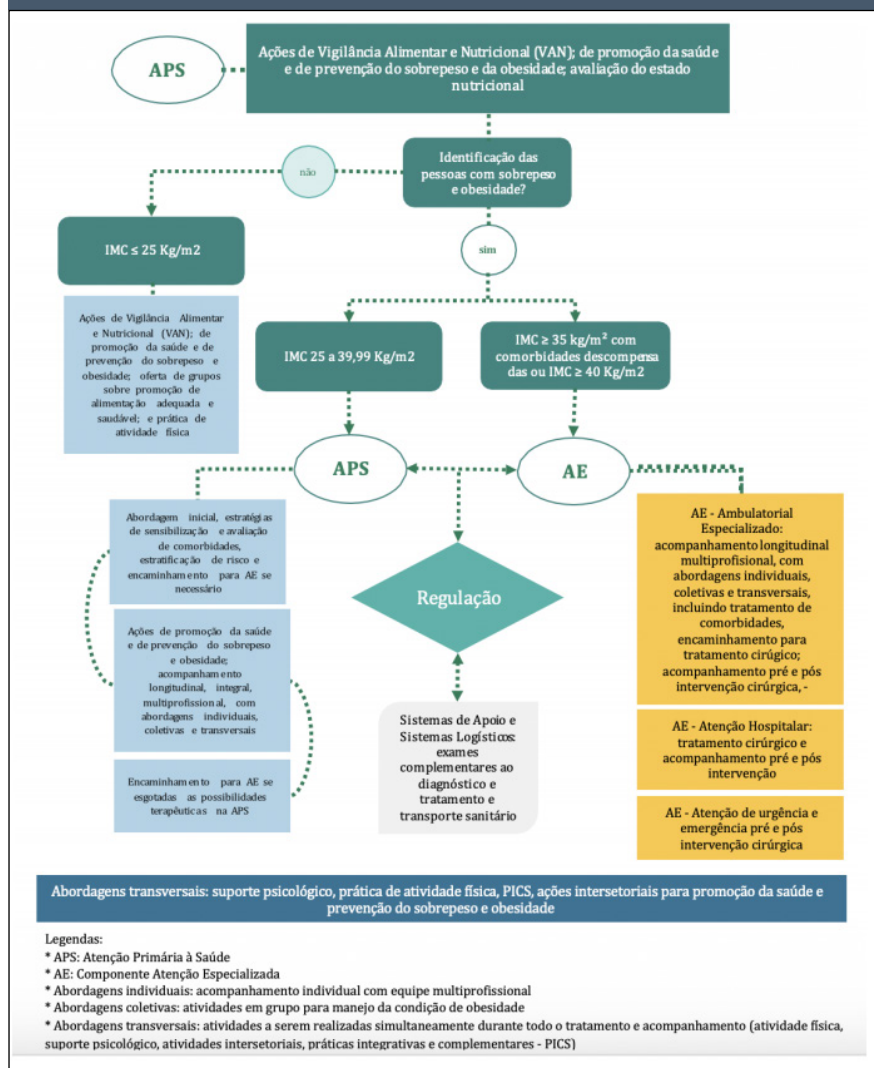
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tion between levels of care proved fragile, with discontinuity in the transition between PHC and more complex services. The presence of multi-disciplinary teams – as envisaged by e-Multi – was partial and insufficient to deal with the most complex cases. The follow-up of a patient with a complex surgical wound at the Araújo Lima outpatient clinic revealed flaws in the linearity of care. The absence of standardized supplies and adequate technical support in PHC highlighted the lack of coordination between levels of care. Such failures increase the risk of complications, prolong recovery time, compromise the principle of comprehensiveness, and hinder access to bariatric surgery.

V. Study Limitations

The study has some limitations. First, technical visits were restricted to a limited number of units and institutions, which may compromise the generalization of the findings. In addition, it was not possible to obtain specific data on the flow of the obesity care pathway in the Southern Health District, which reduced the scope of the territorial analysis. Another point to highlight is that the qualitative survey did not directly cover users' perceptions, limiting itself to institutional observation and interviews with professionals. Despite these limitations, the data obtained allow us to identify recurring barriers and point to directions for improving the obesity care network. Triangulation with the literature reinforces the validity of the findings and indicates the need for public policies that promote integration, continuing education, and greater equity in the provision of services.

Flowchart 2. Management of overweight and obese patients from primary care to bariatric surgery.



Source: BRAZIL. Ministry of Health. *Therapeutic planning*. Available at: <https://linhasdecuidado.saude.gov.br/portal/obesidade-no-adulto/unidade-de-atencao-primaria/planejamento-terapeutico/>. Accessed on: July 2, 2025.

CONCLUSION

This study showed that psychosocial and economic factors have a significant impact on access to bariatric surgery and health services in general. During the visits, it was possible to observe that these factors negatively influence patient adherence and prognosis, as well as the quality of services offered, generating significant deviations between normative guide-

lines—which value comprehensiveness, universality, and quality of service—and the concrete experience—with alarming inequalities and precariousness experienced by SUS users and employees, among which the following stood out: socioeconomic inequality, lack of psychological support, educational deficits for professionals and patients, and structural problems in the health units visited. Therefore, improving the effectiveness of the intervention studied and comprehensive care for patients with obesity must necessarily involve multisectoral public policies that mitigate the problems reported.

REFERENCES

1. World Health Organization. Obesity and overweight: fact sheet [Internet]. Geneva: WHO; 2021 [cited 2025 Jun 27]. Available from: <https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight>
2. Associação Brasileira para o Estudo da Obesidade e da Síndrome Metabólica. Diretrizes brasileiras de obesidade 2016. 4ª ed. São Paulo: ABESO; 2016.
3. Brasil. Ministério da Saúde. Vigitel Brasil 2021: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico. Brasília: Ministério da Saúde; 2021.
4. Associação Brasileira para o Estudo da Obesidade e da Síndrome Metabólica. Mapa da obesidade 2021. São Paulo: ABE-SO; 2021.
5. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Estratégias para o cuidado da pessoa com doença crônica: obesidade. Brasília: Ministério da Saúde; 2014. (Cadernos de Atenção Básica, n. 38).
6. Brasil. Ministério da Saúde. Portaria nº 424, de 19 de março de 2013. Redefine os critérios e os parâmetros para a realização de cirurgia bariátrica no âmbito do SUS. Diário Oficial da União. 2013 mar 20; Seção 1.
7. Sociedade Brasileira de Cirurgia Bariátrica e Metabólica. Censo 2019: dados nacionais sobre cirurgia bariátrica. São Paulo: SBCBM; 2019.
8. Distrito Federal. Secretaria de Saúde. Linha de cuidado da obesidade: protocolo clínico da SES/DF. Brasília: SES-DF; 2021.
9. Palmeira L, Pinto-Gouveia J, Cunha M. Disrupted eating behaviors and psychological symptoms in individuals seeking obesity treatment: the role of emotional regulation. *Eat. Behav.* 2019;33:23-30.
10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Estratégias para o cuidado da pessoa com doença crônica: o cuidado da pessoa tabagista. Brasília: Ministério da Saúde; 2015. (Cadernos de Atenção Básica, n. 40).
11. Brasil. Ministério da Saúde. Secretaria de Atenção Primária à Saúde. Departamento de Promoção da Saúde. Caderno dos Programas Nacionais de Suplementação de Micronutrientes [Internet]. Brasília: Ministério da Saúde; 2022 [cited 2025 Jun 27]. Available from: https://bvsmms.saude.gov.br/bvs/publicacoes/caderno_programas_nacionais_suplementacao_micronutrientes.pdf
12. Brasil. Ministério da Saúde; Ministério da Educação. Caderno temático do Programa Saúde na Escola: alimentação saudável e prevenção da obesidade [Internet]. Brasília: Ministério da Saúde; 2022 [cited 2025 Jun 27]. Available from: http://bvsmms.saude.gov.br/bvs/publicacoes/caderno_tematico_pse_alimentacao_saudavel.pdf
13. Brasil. Ministério da Saúde; Universidade de Brasília. Protocolos de uso do Guia Alimentar para a População Brasileira: orientação alimentar de pessoas adultas com obesidade, hipertensão arterial e diabetes mellitus: bases teóricas e metodológicas [Internet]. Brasília: Ministério da Saúde; 2022 [cited 2025 Jun 27]. (Protocolos de uso do Guia Alimentar para a População Brasileira; v. 1). Available from: http://bvsmms.saude.gov.br/bvs/publicacoes/fasciculo1_protocolos_alimentar_adultas_obesidade.pdf
14. Brasil. Ministério da Saúde. Guia alimentar para a população brasileira [Internet]. 2ª ed. Brasília: Ministério da Saúde; 2014 [cited 2025 Jun 27]. Available from: https://bvsmms.saude.gov.br/bvs/publicacoes/guia_alimentar_populacao_brasileira_2ed.pdf
15. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Instrutivo para a metodologia de trabalho em alimentação e nutrição na atenção básica em saúde [Internet]. Brasília: Ministério da Saúde; 2012 [cited 2025 Jun 27]. Available from: https://bvsmms.saude.gov.br/bvs/publicacoes/instrutivo_metodologia_trabalho_alimentacao_nutricao.pdf
16. Brasil. Ministério da Saúde. Marco de referência da vigilância alimentar e nutricional na atenção básica [Internet]. Brasília: Ministério da Saúde; 2015 [cited 2025 Jun 27]. Available from: https://bvsmms.saude.gov.br/bvs/publicacoes/marco_referencia_vigilancia_alimentar.pdf
17. Brasil. Ministério da Saúde. Orientações para a coleta e análise de dados antropométricos em serviços de saúde: norma técnica do Sistema de Vigilância Alimentar e Nutricional – SISVAN [Internet]. Brasília: Ministério da Saúde; 2011 [cited 2025 Jun 27]. Available from: https://bvsmms.saude.gov.br/bvs/publicacoes/orientacoes_coleta_analise_dados_antropometricos.pdf
18. Brasil. Ministério da Saúde; Organização Pan-Americana da Saúde. Perspectivas e desafios no cuidado às pessoas com obesidade no SUS: resultados do Laboratório de Inovação no manejo da obesidade nas Redes de Atenção à Saúde. Brasília: Ministério da Saúde; 2014. (Série Técnica Redes Integradas de Atenção à Saúde, v. 10).
19. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Alimentação e Nutrição [Internet]. 1ª ed., 1ª reimpr. Brasília: Ministério da Saúde; 2013 [cited 2025 Jun 27]. Available from: https://bvsmms.saude.gov.br/bvs/publicacoes/politica_nacional_alimentacao_nutricao.pdf
20. Manaus (Município). Secretaria Municipal de Saúde. Programa HIPERDIA: Núcleo de Atenção à Saúde das Pessoas com Doenças Circulatórias e Diabetes. Manaus: Secretaria Municipal de Saúde; 2024.
21. Manaus (Município). Secretaria Municipal de Saúde. Nota Técnica nº 008/2024 – NUDRON/GECC/DAP/SUBGS/SEMSA: Processo de trabalho das unidades de saúde no atendimento ao usuário com alteração do IMC. Manaus: SEMSA; 2024 maio 24.
22. Brasil. Ministério da Saúde. Planejamento terapêutico [Internet]. Brasília: Ministério da Saúde; [s.d.] [cited 2025 Jul 4]. Available from: <https://linhasdecuidado.saude.gov.br/porta/obesidade-no-adulto/unidade-de-atencao-primaria/planejamento-terapeutico/>