Table 1 Systematics for conducting the evaluation, according to the five dimensions of the RE-AIM

Dimension	Variable	Northing questions for data collection	Data source	Operationalization
Alcance	It is the number of users who pass through the Program, the proportion of the population participating, and the representativeness of the users of the program in relation to the eligible population.			
	R1. Description of the target population.	R.1.1. What is the number of active users registered in the program?	R.1.1. Documentary research in the Program.	R.1.1. The number of active program users was obtained through the registration form contained in the Program files (n=6).
		R.1.2. How do you identify the target population of the program?	R.1.2. Interview with professionals and coordinators of the Program (Apendices E-F) and documentary research in the program's regulations.	R.1.2. To identify the target population, interviews were conducted with professionals and coordinators who work directly in the Program to find out who the Program is directed to and how the target population is identified through program normative data.
		R.1.3. What are the characteristics (sociodemographic, clinical, anthropometric and lifestyle profile) of the program population?	R.1.3. Questionnaire applied to parents/guardians of children/adolescents.	R.1.3. To measure the characteristics of the target population, a questionnaire was applied (Appendix D), to the parents/guardians of active users of the Program (n = 6), using the following sociodemographic variables: gender, age, education of guardians (years of study); economic data: family income per capita; health conditions and quality of life; reported morbidity, use of medications, perception and satisfaction with health and perception of quality of life.
	R.2. Participation fee.	R.2.1. How many are eligible for the Program?	R.2. Documentary research through data from the Central	R.2. To measure the participation rate in the Program, the number of eligible people who started the

			Consultation Regulation of the Municipality of Recife (those eligible for Good Morning) and data from the individual registration form of users, available in the PAC hub (data of those who started the Program).	Program in the period 2016 to 2020 (n = 35) was divided by the number of the eligible population of the CMEM (n = 3,969) in that same period.
		R.2.2. How many of the eligible people participate in the Program?		
	R.3. Factors that negatively influenced reach.	A.3. What are the main barriers to achieving the Program?	R.3. Interview applied to professionals and coordinators of the intervention.	R.3. The data were obtained through a guide questionnaire for semi-structured interviews (Appendix E-F), applied to professionals working in the intervention and with the program coordinators (n = 17).

Dimension	**Variable**	**Northing questions for data collection**	**Data source**	**Operationalization**
EFFECTIVENESS	It is related to how much the Program causes changes in health outcomes and quality of life of users of the program.			
	E.3. Individual abandonment rate.	E.3.1. How many eligible people started the Program?	E.3.1. / E.3.2. Documentary research through the individual registration ofthe eligible people who started the Program, available at the Program's Administrative Secretariat.	E.3.1. / E.3.2. Calculation of the Abandonment Rate: p calculatesthe rate, divides the number of users who started the Program and gave up in the period between 2016 and 2020 by the number of eligible who started the Program and remain active and multiplied by 100.
		E.3.2. How many Program users have given up?		
		E.3.3. What are the main reasons for abandoning the intervention?	E.3.3. Interviews with program participants (professionals and coordinators).	E.3.3. For the survey of qualitative data related to abandonment, interviews were conducted with the main participants of the program who work in the activities, thus obtaining information about the main reasons that may lead to abandonment.

ADOPTION	The proportion and representativeness of the place and eligible higher education professionals who are willing to implement the Program.			
	A.1. Description of the location that adopted the Program.	A.1. What are the characteristics of the place that adopted the Program (characteristics of the neighborhood, the population served, etc.)?	A.1.1 Cmem institutional documents and data from the Recife Municipal Plan (PMR), 2018-2021.	A.1.1 The data were collected in documents of the institution, provided by the CMEM coordinator. Physical data were obtained from the site, population detailing. Data on geographic coverage were taken from the PMR 2018-2021 available on the Recife City Hall website.
			A.1.2 Field diary.	A.1.2 to complement the data on the physical characteristics of the Program site, eight field visits were made and the data were recorded in the field diary.
	A.2. Participation rate of intervention professionals.	A.2.1. How many professionals are eligible to work in the intervention? **A.2.2.** How many professionals agreed to participate in the intervention?	A.2. Semi-structured interviews with CMEM and CAP coordinator (n=2).	A.2. To calculate the participation rate in the Program, the number of participants in the Bom Dia Program team (n=10) was divided by the number of professionals-eligible for the Program (n=10), multiplied by 100.

Dimension	Variable	Northing questions for data collection	Data source	Operationalization
ADOPTION	The proportion and representativeness of the place and eligible higher education professionals who are willing to implement the Program.			
	A.3. Characteristic of intervention professionals.	A.3. Professional training and bonding in the Program: What is your professional training? When did you start working on the program? What is the highest level of training of professionals in the Program? How are the	A.3. Semi-structured interview with professionals and coordinators of the intervention (Appendices	A.3. To obtain the data that determine the characteristics of the team, semi-structured interviews (Appendices E-F) were conducted with professionals and coordinators (n=11). The distribution, according to the area of

		professionals who work in the Program hired (employment) ? Who pays them? How much time does each professional, in hours, spend on the Program? Were the program professionals trained to act in the function? Do professionals participate in training (continuing education, courses, lectures, etc.)? If so, what do they consist of? Who are they offered by?	E-F).	activity, the time spent in hours per week in the Program was quantified, and source of income. Issues related to the time of action in the Program, and the positive points and limitations on the adoption of the intervention were also raised. All interviews were recorded and transcribed, later grouped the answers in their encoders.
Implementation	The extent to which actions are being put into practice as intended in the Program.			
	I.1. Structure and characteristic of the Program.	I.1.1 Relationship between productions, proposed activities and goals?	I.1. Documentary research through] the normative components of the Bom Dia program.	I.1. It was obtained through observation guided by a script (Appendix C) at the moments of the actions and information contained in the program regulations, to detail the structure of the Program (number, frequency, duration of contact), and the proposals and goals of the activities.
		I.1.2 What are the characteristics of the Program's activities?	I.1. Targeted observation.	

Dimension	Variable	Northing questions for data collection	Data Source	Operationalization
Implementation	The extent to which actions are being put into practice as intended in the Program.			
	I.2. Consistency of delivery.	I.2.1. How often do program meetings?	I.2.1. / I.2.2. Targeted observation.	I.2.1. / I.2.2. Detailed reports on the development of the proposed activities, completed through a checklist (Appendix C).
		I.2.2. How long and during what period are each meeting held?		
		I.2.3. How are activities delivered?	I.2.3. Field diary.	I.2.3 A field diary was used as a qualitative instrument to describe the main activities developed in the meetings, starting with obtaining contact with the guardians of the children who were in the waiting room, and then observing the activities.
	I.3. Compliance with the planning between site and intervention team.	I.3.1. Are the activities as planned?	I.3.1. / I.3.2. / I.3.5. / I.3.6. Targeted observation.	I.3.1. / I.3.2. / I.3.5. / I.3.6. The data were obtained after observation during the meetings, and detailed reports on the changes in the proposed activities were completed in the field diary. During the meetings, the adaptations were recorded, with the Program project as the basis.
		· I.3.2. Has there been a change in the implementation process of the Program?		
		· I.3.3. What reasons led to the adaptations of the protocol for implementing the intervention?	I.3.3. / I.3.4. / I.3.5. Interviews with intervention professionals.	I.3.3/I.3.4/I.3.5. Semi-structured interview with intervention professionals (Appendix E) to obtain data on compliance with the plan and what reasons for adaptations over time. All interviews were recorded and transcribed, later grouped the answers in their encoders.
		· I.3.4. Did the site have to adapt to the program's activities?		
		· I.3.5. Are program activities carried out by the professional team according to the planning?		

		What factors influence planning compliance?
		I-I- I.. 3.6. Can the intervention professionals carry out the proposed activities without difficulties?

Dimension	**Variable**	**Northing questions for data collection**	**Data source**	**Operationalization**
Implementation	The extent to which actions are being put into practice as intended in the Program.			
	I.4. Barriers and potentialities of the implementation process.	I.4.1. What factors have helped in the implementation of the Program?		I.4. It was obtained through semi-structured interviews with coordinator and program professionals (Appendices E, F), with the objective of verifying the challenges and successes for the implementation of the Program. Thus, all interviews took place in a reserved environment and individually, and the identity of each participant was preserved (in this study each person team member received the designation of "P" followed by a number and the coordinators received "C" followed by a number). All interviews were recorded and transcribed, later grouped the answers in their encoders.
		I.4.2. What factors made the implementation of the Program difficult?	I.4. Interview with coordinator and intervention professionals (n=11).	
Maintenance	It is the maintenance of the Program after adoption and implementation.			
	M.1. Organizational maintenance.	M. 1. How was the Program integrated into the municipal health system?	M.1. Interview with cmem and cap coordinator (n=2).	M.1. It was obtained through semi-structured interviews with coordinators of the CAP and CMEM (Appendix F), with the objective of verifying the extent to which the Program becomes part of the municipal health system,

			regardless of political changes. All interviews were recorded and transcribed, later grouped the answers in their encoders.
M.2 Barreiras and potentialities for the continuity of the intervention.	M.2.1. What are the barriers to intervention remain at the organizational level over time?	M.2.1/M.2.2 Interview with CMEM and CAP coordinator (n=2).	M.2. It was obtained through semi-structured interviews with CAP and CMEM coordinators (Appendix F), with questions related to influencing factors for continuity of intervention. All interviews were recorded and transcribed, later grouped the answers in their encoders.
	M.2.2 What are the main potentials for maintenance at the organizational level of Bom Dia?		

Source: Prepared by the author (2021).