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Secretaria de Atenção à Saúde
Departamento de Atenção Básica

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"...Access to food is a human right in itself, insofar as food constitutes the very right to life... to deny this right is, before all else, to deny the first condition for citizenship, which is life itself."

(Brazilian report for World Food Summit, Rome - 1994)

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Edict N.º 710, 10 June 1999

The National Minister of Health, by the power vested in his position, and

Considering it a necessity that the health sector dispose of a duly specific policy regarding food and nutrition;

Considering the conclusion of the aforementioned policy's elaboration process, which included consultations with different segments directly and indirectly involved with the subject; and

Considering the approval of the policy proposal mentioned by the Tripartite Interdirectorial Committee and the National Council of Health, has resolved:

Art. 1. To approve the National Food and Nutrition Policy, which is included within, and forms an integral part of, this Edict.

Art. 2. To determine that the organs and entities of the Ministry of Health, whose actions are related to the objectives in the area of the now-approved Policy, promote the elaboration or readaptation of their plans, programs, projects and activities in accordance with the directives and responsibilities established in it.

Art. 3. This Edict enters in force on the date of its publication.

José Serra
Minister of Health

1 INTRODUCTION

Food and nutrition constitute basic requisites for the promotion and protection of health, in turn making possible the full realization of the potential for growth and human development, quality of life and the practice of citizenship. At both the individual and collective level, these attributes first stated in the fifty-year-old Universal Human Rights Declaration have subsequently been reaffirmed by the 1966 International Economic, Social and Cultural Rights Pact, and incorporated into national legislation in 1992.

Making human rights a reality, particularly in the areas of food and nutrition, involves responsibility not just on the part of the State, but of society and individuals as well. Thus, the human being's condition as an active force in development is inscribed in the preamble to the Universal Human Rights Declaration and also stated explicitly in the 1986 UN Declaration on the Right to Development, in the following terms: "Only when all human beings, individually and collectively, with full respect for each individual's human rights and fundamental liberties, take responsibility for development and recognize their obligations to the community, will the free and complete realization of human potential be guaranteed."

To respect, protect and facilitate the actions of individuals and communities in their quest to feed themselves with dignity, while collaborating towards the goal of providing a healthy, active and participative quality life for all is the duty of the State. In situations such as natural disasters – droughts and floods, for example – which limit access to healthy, suitable food; or in circumstances of structuralized poverty, it falls to the State, in partnership with civil society where possible, to guarantee the human right to food and adequate nutrition. The State's actions in these cases should always be associated with measures which provide conditions for individuals, families and communities to recuperate, within the shortest time possible, the capacity to produce and/or acquire their own food.

Nutritional risks of different categories and magnitudes permeate the entire cycle of human life, from conception to old age, assuming diverse epidemiological configurations in function of the health/sickness process of each population.

In the last three decades, the emergence of this evidence has led to an ample consensus and food and nutritional security has come to be considered a basic requisite for the full realization of the potential for physical, mental and social development of every human being (Valente, 1997).

The concept of food security, which was previously limited to supply in appropriate quantity, has been enlarged to include universal access to food, its nutritional aspects, and, consequently, questions relative to its composition, quality and biological utilization. Brazil adopted this new concept in 1986, with the I National Conference of Food and Nutrition, consolidating it in 1994 with the realization of the II National Conference of Food Security.

Thus, in the aggregate of components which constitute a national policy directed toward food and nutritional security are found agricultural credits, including incentives for small farmers; the evaluation and adoption of agricultural and industrial technologies; strategic stocking; formation of cooperatives; importation; access to, and distribution, conservation and storage of foods; and sustainable management of natural resources; among others.

While actions directed at guaranteeing this security present practical consequences for the human right to food and nutrition, they extend beyond the health sector, taking on an intersectorial character, especially with respect to production and consumption, which necessarily encompasses the acquisitive power of the population and its ability to choose which foods should be eaten, including cultural factors that interfere in that selection process.

Both the adoption of the concept of food and nutritional security on the world front, as well as the Brazilian government's revival of discussions on the subject, have made it easier to understand the role of the health sector regarding food and nutrition, recognized as essential elements for the promotion, protection and recuperation of health.

The health sector's actuation in the context of food and nutritional security has two distinct aspects, which can be named the positive and the critical.

The positive aspect occurs when the supply, distribution and consumption of foods made possible by means outside the sector, and with the participation of society, takes place normally, whether in terms of quantity, quality and regularity or in terms of biological utilization. Under these positive conditions, the predominant actions of the health sector are food and nutritional supervision, sanitary surveillance of foods and educational efforts.

The critical aspect occurs when there is a lack in the supply, consumption or standard of biological utilization of foods. Under these circumstances, obstacles outside the sector, such as insufficient income, a drop in production or interruption of supply; or related to the sector, as, for example, misinformation and inadequate dietary habits, or instances of endemic or epidemic diseases and injuries, lead to problems which affect the health of the population and which must be resolved by the health sector: malnutrition, specific deficiencies, obesity, diabetes mellitus, dislipidemias and associations with other chronic diseases of recognized epidemiological relevance.

These questions are duly contemplated within the legal framework relating to the National Health System (SUS – Sistema Único de Saúde). According to the 3rd Article of Law No. 8.080/90, nourishment constitutes a determining and conditioning factor for the population's health, the level of which expresses "the social and economic organization of the country",.Article 6 establishes as specific attributes of SUS, "nutritional supervision and dietary orientation", and "the control of consumer goods which directly or indirectly relate to health, at all stages and processes, from production to consumption".

Meanwhile, the single paragraph of Article 12 states that the articulation of policy components and diet and nutrition programs, whose elaboration and execution are outside the health sector, must be accomplished by a specific Intersectorial Commission. A subordinate of the National Council of Health, this commission should consist of "ministries and competent organs and entities representative of civil society".

On the other hand, problems inherent to inadequate diet and nutrition are innumerable. According to information provided by Unicef (1998), approximately 55% of childhood deaths in developing countries can be attributed to malnutrition, making this an unprecedented health problem in mankind's recent history, despite advances obtained in reducing the prevalence of the problem. While death is its most serious consequence, energy-protein malnutrition can also aggravate the progress of other diseases, prolonging hospitalization and affecting mental development.

Data from a 1996 population-based study done by the National Health and Demographics Survey indicate that 10.5% of Brazilian children present insufficient growth (<-2dp), and that the prevalence of this condition varies notably by region, ranging from 5.1% in the South to 17.9% in the Northeast.

The country also presents unfavorable statistics in weight/age ratio (<-2dp), with deficiencies occurring in 5.7% of children under 5, at greatest frequencies in the North (7.7%) and Northeast (8.3%). Even with a 20% reduction in energy-protein malnutrition, the last decade has still seen a considerable contingent of Brazilian children between the critical ages of 6 -23 months suffering significant growth delays with regard to weight/age ratio.

Another dietary-nutritional priority is the question of micronutrient deficiency. Recent evaluations of the vitamin A/iron/iodine trinomial indicate great cause for concern.

According to a Project HOPE publication, Vitamin A deficiency constitutes an endemic problem across vast areas of the North, Northeast and Southeast. Despite a shortage of information, it is possible to identify the children's population of the Northeast as the most vulnerable to this condition, with between 16% and 55% of these children presenting Vitamin A levels below 20 mcg/dl, considered a situation of endemic deprivation according to McAuliffe & colleagues (1991), Diniz (1997) and Veras & colleagues (1998).

At the same time, there exist indications of vitamin A deficiencies in impoverished pockets of Minas Gerais and São Paulo, as well as in areas of the North. In these areas, more than 15% of blood samples examined demonstrate Vitamin A levels below the necessary limits.

This deficiency, besides being the world's leading cause of avoidable blindness, is responsible for 23% of childhood deaths due to diarrhea. Studies promoted by Unicef in 1980 indicated that around 25% of the survivors of advanced xerophthalmia lost their vision completely, and that clinical signs of Vitamin A deficiency are almost always accompanied by manifestations of energy-protein deficiency as well. In both cases, the infections play a significant role.

Regarding iron deficiency, anemia stands out as the country's greatest nutritional problem, attacking above all women in their childbearing years and children under two. It is estimated that out of every ten pregnant women in pre-natal care, three are anemic; the proportion of children is even greater: 50% or more (Arruda, 1995).

To illustrate a point, in the state of São Paulo where notable advances have been obtained in the reduction of infant and pre-school age mortality, as well as in the control of childhood malnutrition, the last 22 years have still seen a greater than 100% rise in the frequency of childhood anemia, with rates going from 22% in 1974 to 35% in 1985 and 46% in 1996 (Monteiro, 1997).

Goiter and other disturbances related to iodine deficiency must also be considered serious problems. With the associated risks of cretinism and irreversible deaf-muteness, they constitute the principal factor in avoidable idiocy in the world. A national inquiry performed in 1994-95 by the then National Food and Nutrition Institute researched the prevalence of goiter among school-age children from ages 6 to 14. It was observed

that the problem is concentrated in specific areas of the country, the states of Mato Grosso do Sul, Mato Grosso, Rondônia, Amazonas and Acre.

This study also analysed iodine concentration in urine, currently the most recommended biochemical indicator, given the questionable validity and precision of measuring goiters by palpation. According to this biochemical testing, only the state of Tocantins presented iodine deficiency on a global scale; however, in 35% of all municipalities studied, 10% or more of the schoolchildren presented very low iodine levels based on urinary excretion. These municipalities were concentrated in the states of Tocantins, Goiás, Mato Grosso, and Mato Grosso do Sul.

Another extremely important occurrence in Brazil's food and nutrition scenario is the maintenance of as yet unsatisfactory indices of exclusive breastfeeding of infants, despite relevant progress observed in the last decades.

An analysis by the Oswaldo Cruz Foundation relating the practice of breastfeeding to family economics reveals that if all children born in 1995 had been fed exclusively on breastmilk until six months of age, it would have saved 423.8 million liters of milk at a cost of more than \$200 million. If breastfeeding practices followed the current recommendations, besides the incalculable benefits to children's health, nutrition and well-being, the expenses of families with breastfeeding-age children would certainly be considerably reduced.

Living with so many deficiencies on the one side, on the other, Brazil is experiencing an epidemic evolution of obesity, dislipidemias and the cardiovascular problems associated with these conditions. At today's levels, it is an epidemiological situation never before seen.

According to a 1996 collective report by the Interamerican Development Bank and the World Health Organization, increments of obesity and diet-related chronic diseases, particularly among groups at lower socioeconomic levels, has reached proportions on the order of 50% among adults.

Obesity in the Brazilian population is appearing with more frequency than childhood malnutrition, signalling an epidemiological transition process that must be duly accounted for in the collective health plan. Cardiovascular diseases, which represent the principal cause of death and incapacity in adult life and old age, are responsible in Brazil for 34% of all causes of death, and are largely related to obesity and inadequate dietary practices and lifestyles.

It can be noted that the anthropometric evaluation of Brazilian adults by the Body Mass Index, result of the National Health and Nutrition Survey performed in 1989 and released in 1990, indicated that 24.6% of those studied presented overweight, while 8.3% were obese. The problem is also beginning to appear in children and adolescents. The results of the 1990 Multicentered Study of the Prevalence of Diabetes Mellitus, promoted by the Ministry of Health, showed the occurrence of cases in 7.6% of the 30-69-year-old age group. It is estimated that Brazil has 5 million diabetics, 50% of whom are unaware of their condition.

Added to these problems, inappropriate eating habits constitute another great challenge. In different regions of Brazil, the popular culture still preserves erroneous

traditions and dietary practices concerning the nutritive value of foods, their therapeutic properties, and the indication or prohibition of certain foods or food combinations. Standing out on the other side is the proliferation of fast food businesses and the growing use of pre-cooked or rapid-cooking food products whose nutritional quality is dependent on modern production techniques.

Another influence on dietary habits is the significant volume of institutional meals served on a daily basis to different segments of the population, including 36 million school lunches, meals for 300 thousand Armed Forces members, and meals for the 10 million participants of the Meals for Workers Program (Programa de Alimentação do Trabalhador - PAT).

To adequately serve the nutritional needs of a variety of specific population groups becomes another great challenge. The high index of urbanization and great concentration of humanity in Brazil's large metropolitan centers requires a production sector organized to respond in volume, quality and price, by means of the utilization of appropriate techniques of production, industrialization, conservation and distribution of foods.

Regarding the question of industrialized foods, which directly involves the complex matter of sanitary surveillance, it is important to take into account the quantity of products and companies in existence. Brazil can currently count some 100 thousand food products and 20 thousand registered companies.

Another angle that must be considered is the growing flux of imported foods, necessitating even greater sanitary vigilance. Moreover, there are many relevant factors tied to the safety and quality of food products as, for example:

- scientific and technological advances relating to the evaluation of the nutritional value of foods;
- the effects of techniques of industrialization, conservation, food enrichment and culinary preparation;
- nutritional necessities of the individual under different physiological and pathological conditions, demographic transitions, and nutritional consequences of particular lifestyles; and
- the implementation of and supervision of the fulfillment of pertinent legislation.

Another important analysis within the context of food and nutrition concerns regional differentiations. The 1997 Human Development Report details the reduction of poverty in the country, with measures and standards that vary internally, reflecting how the Human Poverty Index (IPH) differs significantly from one region to another.

The IPH found in the Northeast was 46%; while in the South and Southeast, it reached levels of 17% and 14%, respectively. Studies point out that these disparities have grown during the last two decades, with the prevalence of poverty undergoing a 2/3 reduction in the South and merely a 1/3 reduction in the Northeast (PNUD, 1997). While in the urban population of the Northeast, 13% of children evidence below normal height, in

the rural zone, the figure jumps to 25.2%, both sharply contrasting with a rate of 4.6% in the urban Central-South of the country.

Analysing past and recent tendencies in urban areas of the North, it can be seen that the decline in the prevalence of poverty is smaller than that observed in the rest of the country. In 1996, the highest indices of growth deficit in the urban population were found in the North, and no longer in the Northeast.

Thus, it can be stated that Brazil's situation with regard to food and nutrition is a complex one, featuring considerably heterogeneous epidemiological and regional characteristics, and presenting problems typical of both developed and underdeveloped societies.

2. OBJECTIVE

The present National Food and Nutrition Policy is at once a part of the National Health Policy, while at the same time fitting into the context of Food and Nutritional Security.

In this multidimensional form - the product of joining together those government policies concerned with making the universal human right to adequate food and nutrition a reality - this Policy's objective is **to guarantee the quality of foods available for consumption in this country, to promote healthy dietary practices and to prevent and control nutritional disorders, as well as to stimulate intersectorial actions which favor universal access to food.**

To assure human rights in the sphere of food and nutrition, the definition of this sectorial Policy has encompassed a revision of concepts based on an analysis of the food and nutrition situation of the population, taking into account its diversity and the necessity for differentiated treatments. This revision implies, as a consequence, the reshaping of practices, by means of the formulation or readaptation of the plans, programs, projects or activities that put into operation the guidelines set by this National Policy.

3. GUIDELINES

To attain the objective of the National Food and Nutrition Policy, the following guidelines have been defined:

- Stimulation of intersectorial actions that favor universal access to food
- Guaranteeing the security and quality of foods and food-related services
- Monitoring the food and nutrition situation
- Promotion of healthy dietary practices and lifestyles
- Prevention and control of nutritional disorders and of food- and nutrition – related diseases
- Promotion of the development of lines of investigation
- Development and capacitation of human resources

3.1. Stimulation of intersectorial actions that favor universal access to food

As the keeper of the epidemiological data relative to the favorable and unfavorable aspects of food and nutrition on the national scale, the health sector should promote ample cooperation with other governmental sectors, with civil society and with the production sector, whose actuation is related to determinants that interfere with universal access to quality foods.

Such intersectorial action consists, therefore , of ample negotiation, and takes into account that the principal determinants of healthy food and nutrition are not under the direct control of the health sector, as for example: access to work, employment and income; production, storage and distribution of agricultural products; agricultural credits and incentives for the small farmer; food stocking; programs to supply food and supplements for different populations and social groups, among which are the programs developed jointly with local and regional food production.

3.2. Guaranteeing the security and quality of foods and food-related services

The redirectioning and strengthening of actions of sanitary surveillance will be the focus of special attention in the search to guarantee the safety and quality of foods and food -related services. These actions constitute a basic instrument in the preservation of those attributes related to the nutritional value of and the criteria for the sanitary quality of foods and food-related services, seeking, within the perspective of the human right to adequate food and nutrition, to protect consumer health.

This question takes on particular importance, especially in view of the constant updates in the technologies of production, industrial processing, conservation, packaging and other aspects that compose the profile of the population's food supply and consumption, including those technologies that control the hazards that traverse the entire food chain.

At all levels of actuation, the establishment of partnerships with related organs of consumer protection and entities of civil society and of the production sector will be sought and stimulated, with the goal of making public that information relevant to the consumer's right to safe, quality food, and facilitating all citizens' access to the mechanisms designed to guarantee this right.

The component of the National Sanitary Surveillance System concerned with foods and food services should be fortified by means of a revision or readaptation of the technical and operational standards, emphasizing those related to preventing health offences. Accomplishing this requires the modernization of inspection methods, with the adoption of control and security measures in the areas of food production and food-related services, taking into particular account the analysis of hazards and the control of critical points, with the aim of preventing food-transmitted illnesses and economic losses due to deterioration.

To this end, the public sector must provide the National Health System's (SUS's) three administrative divisions with an adequate infrastructure, along with funding for the development of actions of sanitary supervision. Along with this, there must be a modernization of standards of efficiency, coordination and control of the process of sanitary supervision, making possible a more agile and consistent actuation at all segments of the food chain, from production, labeling - including nutritional labeling, packaging and repackaging, storage, transport, commercialization and consumption.

National legislation regarding sanitary supervision in the food area needs to be updated, with consideration given to biotechnological advances such as genetic modification and others. The criteria and procedures of supervision need to be made compatible with the legal instruments that govern international agreements. Regarding Mercosur, Brazil must effect the adjustments required to proceed with trading unprocessed and industrialized foods with other member nations.

An intersectorial joint effort will seek to make sanitary supervision procedures developed by the health sector compatible with those of other sectors in order to maximize the use of available resources and avoid duplication of actions and conflict between institutions.

Decentralizing management of sanitary supervision actions to allow more participation at state and municipal levels is another essential step in the quest to guarantee food quality and security.

In the process of decentralization, priority should be given, especially by means of specific financial incentives, to the sanitary supervision of foods, with particular attention to those which, like salt, are micronutrient carriers, and therefore have great collective importance.

3.3. Monitoring the food and nutrition situation

The National Food and Nutrition Surveillance System (Sisvan), expanded and improved to render its procedures more efficient and extend its coverage to the entire country, will monitor the food and nutrition situation. This System must be reinforced with

the support of food and nutrition collaboration centers and work centers, which already exist in almost all states and in hundreds of municipalities in Brazil.

Among its activities, Sisvan will provide a continual description of the population's food and nutrition conditions and their determining factors, and predict tendencies in the area.

The descriptive and analytical diagnosis of the problems and determining factors should highlight those geographical areas and social and biological groups of greatest risk. The analysis of this information will reveal evolutionary tendencies, either spontaneous or conditioned by general and specific interventions.

One priority measure to be implemented is the installation of guardposts from where can be witnessed the epidemiological behavior of problems and their connections with risk indicators. These posts should be organized mainly in areas of, and near to, high-risk populations, facilitating observation of conditions difficult to measure, such as vitamin A and iodine deficiency.

While monitoring the food and nutrition situation, Sisvan should concentrate special attention on expectant mothers and on children's growth and development, serving as a hub for all work undertaken in the service network and giving priority to basic healthcare services and the commitment to making them universally available.

The health services network should be encouraged to incorporate nutritional monitoring of patients into routine consultations, allowing for early detection of risk situations and the corresponding prescription of treatment to prevent negative effects and guarantee reversion to a normal state.

Another priority will be the mapping out of endemic deficiencies such as energy-protein malnutrition, anemia, vitamin A deficiency and iodine deficiency, in order to identify their spatial distribution and the magnitude of their occurrence.

The work of tracking the situation of non-transmittable chronic diseases related to inadequate diet and lifestyles should be compatible in terms of the collection, generation, flux, processing and analysis of data, with systems already in existence, such as: the Mortality Information System (Sistema de Informação de Mortalidade - SIM); the Live Births Information System (Sistema de Informação de Nascidos Vivos - Sinasc); the National Notifiable Offence System (Sistema Nacional de Agravos Notificáveis - Sinan), which includes the registry of serious forms of malnutrition, and the Outpatient Information System (Sistema de Informação Ambulatorial - Siab).

In a more specific form, information systems will focus on the question of breastfeeding, including factors of negative and positive influence; and perform periodic nutritional evaluations of public school students. Other fundamental points of this guideline will be the monitoring of food production and the critical analysis of the qualitative and quantitative evolution of supply and consumption.

In addition, the collection and analysis of macroeconomic and social data indicative of the food situation and, consequently, of widespread or localized security risks, should be emphasized. Events that mobilize large contingents of the population, such as

"national vaccination days", should be taken advantage of as opportunities for the realization of food and nutrition studies.

With this structure, Sisvan will provide support for the design and adjustment of programs, the continual updating, and the systematic analysis of information regarding the country's food and nutrition situation, thus producing the desired feedback between information, action and evaluation of results.

In this way, a basic list can be produced of the indicators capable of signaling events of major interest, such as: availability of foods; qualitative and quantitative aspects of a particular diet; breastfeeding practices and complementary post-weaning diet profile; birthweight distribution; prevalence of energy-protein malnutrition, anemia, overweight, iodine and vitamin A deficiency and other micronutrient deficiencies related to non-transmittable chronic diseases.

3.4. Promotion of healthy dietary practices and lifestyles

The promotion of healthy dietary practices, which begins with the encouragement of breastfeeding, fits into the context of adopting a healthy lifestyle as an important component in promoting good health. To this end, emphasis will be given to the socialization of knowledge concerning food and diet, and to the prevention of nutritional problems, ranging from malnutrition and specific deficiencies to obesity. All educational materials must always cite the human right to food as an indispensable condition for life and for the practice of citizenship.

Actions directed towards encouraging the adoption of healthy dietary practices should include all of the steps delineated by the guidelines defined in this Policy. Beside the initiatives inherent in each specific measure that comes to be adopted, special attention should be given to a permanent educational process concerning questions related to food and nutrition, as well as to the promotion of systematic campaigns of social communication. This will require seeking the involvement of technical-scientific entities, teaching establishments, the media and entities of civil society and the production sector.

Also deserving priority focus are the recovery of regional dietary habits and practices involving consumption of inexpensive, nutritionally-rich locally-produced foods, and of varied dietary recommendations for childhood, adult life and old age.

In addition, special emphasis should be given to the prevention of non-transmittable chronic diseases, such as cardiovascular disease and diabetes mellitus, and their victims oriented as to appropriate diet and how to avoid aggravating their pathologies.

Food and nutrition education contains complex and even conflicting elements. To avoid problems, consensus should be established concerning content, method and educational techniques, taking into account geographical, economic and cultural differences. Promotion of healthy dietary practices must certainly also include specific initiatives to promote breastfeeding, with priority given to women in their childbearing years.

A fundamental first step towards effectuating the priority status granted to encouragement of breastfeeding is the revision of actuation methods and strategies,

particularly within the health sector. This work will necessitate seeking the cooperation of different social segments, especially those with the largest ability to influence breastfeeding practices, such as: entities representative of different categories of health professionals; entities representative of the food and nutrition industry; social and educational communicators; community leaders; consumer defense; extensionists and many types of organizations from civil society.

It will also be important to adopt measures to regulate the marketing of infant formulas, working in partnership with entities from the advertising field, public relations companies, and entities from civil society and the production sector.

Alongside these efforts, support will also be given to institutional programs which meet previously established criteria, as, for example, the "Baby-Friendly Hospital Initiative" and human milk banks, and to movements initiated by non-governmental organizations for the encouragement of breastfeeding.

Milk banks will receive special attention to assure that their activities are reinforced and effectively incorporated into routine healthcare services. These banks must be spread throughout the country.

Specifically, there must be a continual reevaluation of those services used to classify hospitals as "baby-friendly", as well as a revision of the evaluation criteria used to grant "baby-friendly" status, with special attention given to the reformulation of hospital routines in order to facilitate the practice of breastfeeding.

In the area of legislation, those articles which ensure mothers the necessary conditions to breastfeed their children, such as schedules and workplaces compatible with breastfeeding, will be reinforced, expanded and made available to the public. An essential reference for the incorporation of all of these measures are the various national and international codes, regulations and standards regarding the industrialization, commercialization and marketing of processed breastmilk substitutes.

Another relevant measure will be the supervision of the industrialization and commercialization process of pharmaceutical and/or dietetic products which claim to offer therapeutic or prophylactic solutions for nutritional problems, as in the following important examples: control of weight, fatigue or the aging process; prevention and treatment of diseases that are difficult to handle; and other questionable or downright fraudulent claims.

In addition to these efforts, initiatives that permit the supervision and monitoring of marketing practices will be implemented, subject to the criteria and interests that constitute a healthy life. Questions related to overweight and its implications will be examined in this light.

The technical content of the various measures being developed must be consolidated to serve as a base for the elaboration of informative and instructional materials which will be used to support the capacitation of health professionals in the area of dietary orientation.

3.5. Prevention and control of nutritional disorders and of food- and nutrition – related diseases

The lack of a clear division between specific institutional nutritional measures and conventional health interventions demands an actuation based on two polar situations.

In the first situation is the morbidity/mortality scenario, dominated by the malnutrition/infection binomial, affecting primarily poor children in socially and economically backward regions.

In the second is the predominant group of overweight and obesity, diabetes mellitus, cardiovascular diseases and some tumors, having as chosen hosts adults and elderly people although, clearly, many of these problems may have been initiated in childhood.

Measures to handle non-transmittable chronic diseases will concentrate on promoting health and controlling dietary and nutritional deviations as the most effective means to prevent their taking hold and developing.

The dietary and nutritional problems that gravitate around energy-protein malnutrition (DEP) will be approached by way of the family, as it is recognized that the risk factors are defined within a "vulnerable family" context. In practice, this point of view recommends the simultaneous evaluation of other family members, primarily siblings and, eventually, mothers in conditions of physiological overload, such as pregnancy and lactation.

The malnutrition/infection binomial will be dealt with through actions directed at prevention and adequate handling of infectious diseases. The distribution of food and food education constitute indispensable tools to be used in conjunction with the prevention and control of diarrhea, acute respiratory infections and immunopreventable diseases, measures essential to the avoidance of malnutrition or its aggravation. The State's action in these situations should always be associated with measures that seek to provide conditions for individuals, families and communities to recuperate as quickly as possible the capacity to produce or acquire their own food.

Supervision of growth and development will be adopted as the support axis for all activities relevant to children's healthcare. Low birth-weight babies will receive special attention, due to their high degree of vulnerability to malnutrition and infectious disease.

To confront the problems related to low birth-weight and energy-protein malnutrition in children, priority must be granted to standardizing actions connected to risk factors and to the continuation of cases that fit into these conditions in different instances and circumstances of care.

Children at risk for malnutrition, those between 6 and 23 months of age living in regions whose epidemiological reality must be taken into account, will be tended by means of food assistance, control of coexisting diseases and supervision of siblings or contacts, including pregnant women and nursing mothers who may be at nutritional risk, particularly those living in pockets of poverty. Monitoring of nutritional states, fundamental

for the prevention and control of energy-protein malnutrition, will be incorporated into routine healthcare services in such a way that all age categories at risk are covered and that it becomes possible to identify the problem and develop actions directed towards:

- reduction of the frequency of moderate and serious malnutrition in children;
- reduction of the occurrence of anemia and malnutrition in expectant mothers;
- reduction of the incidence of low birth-weight and the supervision of cases that meet this condition.

The types of special care to be given children between six and 23 months of age will be based on the experience of other successful programs already under development in the country. Children in this age group whose weight/age ratio falls below the tenth percentile will be assured food assistance, specific nutritional care and basic healthcare services; for those who fall below the third percentile, requiring even greater attention, actions of nutritional rehabilitation will be developed. The rate of the child's weight gain should also be considered, and not merely his point on a standard children's growth chart.

In relation to micronutrient deficiency and, specifically, to the control of iron deficiency, essential measures to be adopted include food enrichment, educational orientation and, above all, the use of iron supplements.

To reduce the country's rate of anemia due to iron deficiency, a part of Brazil's production of wheat flour and cornmeal, low-cost foods of widespread popular consumption, will be iron-fortified. With this, it is hoped to reduce by up to one third the incidence of iron-deficiency anemia in pre-school-age children by the year 2003, as indicated in an already-signed protocol between the Brazilian government and the production sector.

In the fight against vitamin A deficiency, populations in high-risk areas will not only receive periodic emergency megadoses of retinol, but will also be stimulated to produce and consume food sources rich in this vitamin or its precursors. When necessary, certain foods may also receive vitamin A enrichment/fortification.

In areas of high risk for vitamin A deficiency, the systematic periodic administration of massive doses of this micronutrient to all children under age five will become a part of normal check-up procedures. The enrichment of milk and macaroni products with vitamin A, iron or, eventually, other nutrients should also be promoted.

In light of the epidemiological significance of these nutrient deficiencies, tables charting the chemical-nutritional composition of the principal foods consumed in Brazil need to be amended, emphasizing content and bioavailability of iron and vitamin A precursors.

Disorders due to primary iodine deficiency will be confronted by assuring the legal, administrative and operational conditions to make iodized salt regularly available for human and animal consumption.

As the best way to fight iodine deficiency and guarantee that all salt destined for human and animal consumption receives the enrichment of potassium iodide, systematic measures of control will be implemented, both at the factory stage during the iodine addition process itself, and at the stage of marketing to the consumer.

Achieving this will require a partnership between the government and industrial sectors, based on their shared commitment to iodizing all salt destined for human consumption, regardless of how it is supplied.

Meanwhile, the encouragement of breastfeeding will play a strategic role both in the prevention of energy-protein malnutrition, anemia and vitamin A deficiency, and in the reduction of the incidence, duration and gravity of diarrhea and acute respiratory infections.

The three administrative divisions should consolidate their efforts in the area of breastfeeding, encouraging the practice of exclusive breastfeeding for the first six months of life, followed by the introduction of solid foods accompanied by continued breastfeeding until two years of age.

The purpose of these largely intersectorial efforts is to ensure mothers the necessary conditions to breastfeed their children. With an emphasis on recuperating and reinforcing the culture of breastfeeding, the following measures will be adopted: nutritional supplements for nursing mothers, the Baby-Friendly Hospital Initiative, the creation of human milk banks, informing the public about and supervising of the Brazilian Code for the Marketing of Breastmilk Substitutes; all to be backed up by a program of intensive, adequate and permanent education.

One way to guarantee the execution of these activities is through the transfer of specific federal funds designated for the control of deficiencies and other nutritional disorders. Those municipalities eligible under the administrative conditions established by the Basic Operational Code of 1996 - Complete Basic Healthcare Management and Complete Municipal System Management - and who meet the fixed criteria, can register to receive a financial incentive in conjunction with the Basic Care Grant. The funds will be transferred on a regular and automatic basis directly from the National Health Fund to the Municipal Health Fund.

It is important to point out that within the terms of the edict that deal with the financial incentive destined to bear the costs of measures related to food and nutrition are defined all of the actions to be undertaken, including those inherent to the control of malnutrition and risk groups.

3.6. Promotion of the development of lines of investigation

The implementation of all guidelines of the National Health and Nutrition Policy depends on the support of lines of investigation, developed according to the standards of the National Commission for Ethics in Human Research (Conep/MS), which clarify specific and even general aspects of certain problems, evaluate the contribution of causal factors and indicate the most appropriate measures for their control.

To accomplish this, the lines of research that are established and supported should permit control over the types of situations and factors that are of interest for defining and executing actions related to nutrition.

Among lines of interest, one that stands out is the energy-protein malnutrition problem which, despite having been well-described and analysed in social and geographic terms, is in need of additional updated studies. In the area of micronutrient deficiency, special attention should be given to deepening the as yet very limited knowledge of the epidemiology of anemia and vitamin A deficiency.

Meanwhile, studies still in the preliminary phase concerning the relationship between non-transmittable chronic diseases and dietary profile should be expanded, and their results made available to the public. In fact, the relationship between food consumption and dietary value should become the object of studies which permit a broader analysis of the situation, since most of the currently available data refer only to certain metropolitan areas. Other studies to be promoted are those relative to the cost-benefit and cost-efficiency of programs and actions resulting from this Policy, and epidemiological studies destined to the mapping out of nutritional deficiencies prevalent in the country.

These studies and investigations should lead to the elaboration of national food-composition tables which detail the nutritional value of the principal foods and preparations consumed by the population, with special focus on the bioavailability of iron and vitamin A.

Another line of interest will be the study of the composition and nutritional content of institutional meals, such as those served to the Armed Forces, in school lunches, as part of the Meals for Workers program and by the Social Services of Commerce and Industry, with the idea of promoting healthy dietary practices and habits.

In addition, regional dietary recommendations based on prevalent local habits will be established for all age groups, including breastfeeding babies in transition to solid foods, with particular focus on implementing projects already initiated.

These studies should investigate factors that protect breastfeeding, while also examining proposals and initiatives concerning recommended parameters and standards for the transition to solid foods.

Anthropological and ethnographic studies of dietary habits and practices can help to revive the culture of consumption of traditionally valued foods.

Other undertakings include updating the country's map of dietary and nutritional problems; analysing the risk factors of nutritional endemics of epidemiological importance; and formulating proposals, evaluations and validations of intervention models, taking into consideration efficiency, effectiveness and cost/benefit ratio.

3.7. Development and capacitation of human resources

As a guideline that is the cornerstone of the entire Policy, the development and capacitation of human resources constitutes a privileged mechanism of intersectorial

cooperation, enabling the health sector to dispose of a numerous and capable team of personnel whose adequate and ready supply is the responsibility of the three administrative divisions of government.

The special recognition granted this component is expressed by the single paragraph of Art.14 of Law No. 8.080/90, which establishes that the process of continuous education and training of personnel constitutes an important part of joint intersectorial action. As a fundamental mechanism, the law establishes the creation of a permanent commission of integration between health services and institutions of higher learning and professional training, with the aim of “proposing priorities, methods and strategies”.

Specifically, cooperation with the Ministry of Education must result in the essential adaptation of courses for health professionals to include all aspects inherent in the guidelines of this policy, particularly that content which recognizes the human rights aspect as a central point of the policy.

In the specific sphere of actions, the goal of capacitation is to prepare human resources who can execute, from a human rights perspective, a basic agenda of activities which includes the following: case evaluation; selection of beneficiaries and their proper accommodation by local healthcare services; prevention and adequate handling of illnesses that interfere with the state of nutrition or, under other aspects, with dietary and nutritional conditions that act as relevant risk factors for the development of diseases, particularly those of a non-transmittable, chronic nature.

The capacitation of personnel in the areas of planning, coordination and evaluation of actions should constitute a base for the development of the continuous process of cooperation between the health sector and all other sectors whose actions are directly related to food and nutrition.

Promoting this capacitation recognizes the questions inherent in guaranteeing the human right to adequate food and nutrition. Equally necessary is the preparation of professionals who can provide the level of technical cooperation required by the different circles of administration to standardize concepts and procedures that will prove vital for the realization, continual evaluation and supervision of the National Food and Nutrition Policy.

4. INSTITUTIONAL RESPONSIBILITIES

In keeping with National Health System (SUS) principles, the administrators will, jointly and in accordance with their specific and common attributes, work towards attaining the objective of the National Food and Nutrition Policy, which is **to guarantee the quality of foods available for consumption in this country, to promote healthy dietary practices and to prevent and control nutritional disorders.**

Moreover, considering this Policy's peculiar intersectorial characteristics, and its ties with the Food and Nutritional Security Policy, herewith are detailed the explicit intra- and intersectorial responsibilities of each institution.

4.1. Intra- and Intersectorial Cooperation

Acting within their respective domains, SUS administrators will promote the implementation and evaluation of this Policy establishing, as it were, the necessary process of cooperation with those sectors involved with Food and Nutritional Security, and seeking the establishment of partnerships and interinstitutional cooperation which will allow for the consolidation of multilateral commitments. In the same way, partnerships with society will encourage citizens' effective participation in the realization of the National Food and Nutrition Policy.

Seeking partnerships with the various sectors involved with Food and Nutritional Security and, therefore, committed to the human right to adequate food and nutrition will take into account the adoption or implementation of essential measures whose overflowing impact can have an important effect on public health and, by consequence, on the attainment of this Policy's objective. Herewith are identified the priority institutions and federal sectors, along with the principal noteworthy measures.

A. The Intersectorial Food and Nutrition Commission of the National Health Council

The importance of this commission's function for the consolidation of the Policy, besides its role in effectuating the already-mentioned Law No. 8.080/90 concerns the coordination of policies and programs which are related to food and nutrition, but whose elaboration and execution fall outside of the dominion of the SUS.

In this context, it is important to redefine the composition of the Intersectorial Commission such that it includes representatives from the SUS administration and those sectors involved with Food and Nutritional Security, in order that decisions resulting from National Council of Health resolutions, endorsed by the approval of this commission, are based on reality and have the support of the agents and institutions responsible for their implementation.

The Intersectorial Commission, together with the National Council of Health, should promote the creation of similar commissions at the state and municipal levels.

B. Community Solidarity

Cooperation with Community Solidarity is directed at taking advantage of its ability to mobilize different sectors and, therefore, to have a catalysing effect which facilitates the accomplishment of strategic measures, such as: the integration of food and nutrition programs with other social actions; the circulation of information regarding this Policy; and the promotion of dialogue between the principal governmental and non-governmental players involved in the food and nutrition area.

C. The Ministry of Agriculture and Food Supplies

The partnership with this Ministry aims to:

- identify agricultural programs and strategies with specific nutritional goals and objectives and evaluate their capacity to improve nutritional conditions, using the agroecological model as a reference;
- standardize supervision procedures at the different administrative levels in order to establish operational harmony and an exchange of information between the sanitary supervision of foods performed by the SUS and pertinent actions executed by this Ministry;
- analyse levels and standards of local and home-made food production, including storage and conservation practices;
- evaluate the efficiency of the agricultural extension – credit and technical assistance -, the volume and seasonal availability of foods, the commercialisation, and the connections between the rural and urban market;
- evaluate the impact of the family farm program on food supplies, the difficulties of transition from traditional to modern methods of agriculture, and the consequences with respect to regional disparities;
- utilize state rural extension systems to offer technical assistance to small farmers, with the goal of achieving self-sufficient food production.

D. The Ministry of Budgets and Administration

Most significant among the various measures resulting from the partnership with this ministry are those inherent to the allocation of budgetary resources, the definition of priorities, and the evaluation of the impact of the National Food and Nutrition Policy.

E. Cabinet of the Special Minister of Agrarian Policy

Cooperation with this Cabinet seeks primarily to encourage the mobilization of farmers with a predisposition for self-sufficiency, taking into consideration basic food and nutrition objectives not only from the point of view of the dominant profile of production systems in these agrarian settlements, but also of the social and biological vulnerability to nutritional problems that these projects' beneficiaries present. This mobilization seeks mainly to provide food and nutrition for these communities by means of:

- setting in motion a process that protects small producers and includes them in the globalizing market process;
- providing rural laborers and small farmers with sufficient education to develop their cognitive abilities to decode and adopt new technologies;
- evaluating the investment directed at the agricultural modernization of small farms, such as the incorporation of mechanical and biochemical technologies, using as a reference the agroecological and organizational (commercialization and agroindustrialization) models.

F. The Ministry of Foreign Relations

In light of the formal Mercosur accord between the Ministries of Health of Brazil, Argentina, Uruguay and Paraguay, the cooperation process should involve the establishment of a commitment to action against micronutrient deficiency.

This action implies direct interference in the sectors of production and the transformation of foods, especially in terms of the criteria and standards for the enrichment of popularly consumed industrialized products.

G. The Ministry of Work and Employment

Cooperation with this ministry seeks to:

- evaluate the possibility of measuring the relationship between objectives concerning the improvement of workers' nutritional conditions and the reduction of accidents in the workplace;
- provide supervision and orientation of agents involved in the Meals for Workers Program (PAT) (beneficiary companies and workers and companies providing food supplies or services);
- expansion of the workers' food policy, seeking to extend benefits to workers with the lowest incomes in the neediest regions; and
- identification of PAT's repercussions on economic activity within the various intervening agencies - meal suppliers, grocery-basket distributors,

restaurants, etc. - , the generation of employment and income, and the increase in demand of agricultural and livestock products.

H. The Ministry of Education

Together with this ministry, cooperative efforts promoted by the Ministry of Health center on:

- working jointly with schools and families to promote healthy dietary and nutritional practices;
- reorienting the training of healthcare professionals to reflect the guidelines of this Policy
- evaluating the quality of school lunches and their impact on student growth and development, learning capacity and academic performance;
- evaluating the influence of attitude transformation in the process of incorporating new and better dietary habits, and the possibility of reaching out to families and communities;
- analysing the introduction of educational material about health, foods and nutrition into the basic curriculum; also, preparing material for this purpose and for distance learning activities as well;
- retraining and capacitating teachers to enable them to teach health and nutrition curriculum, as well as to identify nutritional problems;
- introducing the subjects of health , diet and nutrition, including the importance of breastfeeding, into the school curriculum;
- evaluating and intensifying associations with universities and other research and teaching centers for the utilization of analytical capacity and strategic design, as well as for support in the capacitation and training of professionals and community agents.

I. The Ministry of Development, Industry and Commerce and the Ministry of Science and Technology

The Ministry of Health's work on the National Food and Nutrition Project in conjunction with these two ministries will focus on:

- analysing government safeguards for imported foods to assure their quality and germ-free status;
- analysing technological options capable of elevating productivity and profitability of food crops, giving preference to those of an agroecological nature;

- evaluating technologies for the fortification of food products with iodine, iron and vitamin A;
- developing research incentives based on priorities outlined in the Policy.

J. The Ministry of Justice

The goal of cooperation with the Ministry of Justice is to bring about the realization of the universal human right to food and nourishment , encouraging ample consumer defense measures and mobilizing other organs and social segments involved with the question.

4.2. Federal Administrative Responsibilities – Ministry of Health

- To prepare and furnish information, analyses and proposals that contribute to the elaboration and effectiveness-monitoring of extra-sectorial policies which guarantee the respect, protection, facilitation and realization of the human right to adequate food and nutrition, within the context of Food and Nutritional Security.
- To implement and evaluate the effectuation of the guidelines and priorities of the National Food and Nutrition Policy.
- To establish standards and provide states and municipalities with the technical cooperation necessary for implementing the Policy, including systematic measures for the prevention and handling of nutritional problems in individuals, families and communities, counting on technical-scientific support from the Food and Nutrition Collaboration Centers.
- To participate in financing actions resulting from this Policy, designating funds in the form of incentives, specific procedures and other available mechanisms to pay for services and the acquisition, on the part of other SUS administrators, of food and other previously determined materials and resources.
- To promote means of strengthening the Food and Nutritional Surveillance System (Sisvan) to include widening its technical and geographic radius for the purpose of mapping and monitoring hunger, malnutrition and other nutritional problems.
- To orient and support states and municipalities in their process of acquisition of food and other strategic materials and resources, assuring that necessary food and nutrition requirements are met and that supplies are adequate, regular and economical.

- To create mechanisms that link transfer of funds based on state and municipal requests with development of a satisfactory healthcare model.
- To promote the revision of food legislation, especially that related to sanitary supervision.
- To adapt plans, programs, projects and activities to the guidelines and priorities of this Policy.
- To promote the establishment of a laboratory network with the capacity to certify food quality.
- To promote examination and sanitary inspection of foods available for public consumption, according to their degree of risk, and to formulate specific programs for this purpose.
- To implement and consolidate the process of decentralization of actions involving sanitary supervision of food.
- To redefine and coordinate the National Sanitary Surveillance System with regard to food.
- To coordinate and monitor other national systems fundamental for this policy, for example, Epidemiological Supervision and the Public Health Laboratory Network.
- To stimulate and support the carrying out of research considered strategic within the context of this Policy.
- To promote the spread of technical-scientific information and of successful experiments related to the areas of food and nutrition.
- To promote the capacitation of human resources necessary for the implementation of this Policy.
- To promote the adoption of healthy dietary practices and habits by means of the mobilization of different segments of society and through public service advertising campaigns.
- To support states and municipalities in activating measures directed at the elimination or control of risk factors that have been determined by an analysis of tendencies.
- To promote intersectorial negotiations that favor universal access to good quality food.
- To promote social control of the execution of this Policy, including the application of corresponding financial resources, by means of strengthening the action of the National Health Council.

4.3. State Administrative Responsibilities – State Health Secretariat

- To elaborate, coordinate, and execute the State Food and Nutrition Policy, in accordance with the National Policy.
- To promote the elaboration and adaptation of plans, programs, projects and activities in accordance with the State Food and Nutrition Policy.
- To promote the process of intersectorial cooperation within the state, for the purpose of implementing the respective policy.
- To participate in financing actions resulting from the State Policy.
- To participate in the definition and acquisition of foods and strategic materials and resources according to the state's role in the plans, programs, projects and activities that effectuate this Policy.
- To orient and support municipalities in the process of acquisition of foods and other strategic materials and resources, assuring that necessary food and nutrition requirements are met and that supplies are adequate, regular and economical.
- To provide municipalities with technical cooperation for the implementation of actions resulting from this Policy.
- To elaborate and support proposals for strategically important studies and research involving the implementation, evaluation or reorientation of questions related to food and health.
- To coordinate and monitor the state component of national systems essential for carrying out this Policy, some examples being Sanitary Surveillance, Epidemiological Supervision and the Public Health Laboratory Network.
- To promote means of strengthening the state component of the Food and Nutritional Surveillance System (Sisvan) to include widening its technical and geographic radius for the purpose of mapping and monitoring hunger, malnutrition and other nutritional problems.
- To organize and coordinate the state public health laboratory network for the execution of procedures concerning the diagnosis of nutritional disorders and control of the salt iodation process.
- To promote the capacitation of human resources necessary for carrying out the State Food and Nutrition Policy.
- To implement actions of sanitary supervision of foods under the state's supervision.

- To strengthen and maintain relations between sanitary supervision of food, the role of the SUS, and pertinent actions executed by the Ministry and State Secretariats of Agriculture, with the aim of preserving attributes related to the nutritional value and healthfulness criteria of foods.
- To participate in the acquisition of materials and resources destined toward outpatient and hospital care for patients with nutritional disorders.
- To promote proper storage of foods and other materials and resources.
- To promote the adoption of healthy dietary practices and habits by means of the mobilization of different segments of society and through public service advertising campaigns.
- To promote intersectorial negotiations that favor universal access to good quality food.
- To promote social control of the execution of this Policy, including the application of corresponding financial resources, by means of strengthening the action of the respective State Health Council.

4.4 Municipal Administrative Responsibilities – Municipal Health Secretariat or corresponding entities

- To coordinate and execute actions resulting from the National and State Policies in its respective jurisdiction, defining specific components to be implemented by the municipality.
- To receive and/or acquire foods and nutritional supplements, guaranteeing permanent, adequate supplies and their correct distribution.
- To promote necessary measures for the integration of municipal programming with that adopted by the state.
- To promote training and capacitation of human resources for the productive and efficient accomplishment of an agenda of specific activities related to food and nutrition.
- To activate the municipal component of national systems essential for carrying out this Policy, some examples being Sanitary Surveillance, Epidemiological Supervision and the Public Health Laboratory Network.
- To promote means of strengthening the municipal component of the Food and Nutritional Surveillance System (Sisvan).

- To computerize and use systems of analysis with ongoing regularity.
- To establish within the healthcare network, for patients with clinical nutritional disorders, the provision of services such as food assistance, control of diet-related illnesses and the examination of siblings and contacts, guaranteeing the simultaneity of nutrition-related actions with routine healthcare procedures.
- To standardize procedures concerned with evaluation of cases, selection of beneficiaries, and overseeing recuperation from malnutrition; as well as prevention and management of diseases that interfere with nutritional condition.
- To identify and treat nutritional risk in individual and collective situations.
- To obtain information regarding typical food consumption.
- To supervise situations of vitamin A deficiency, including the promotion of periodic applications of megadoses of the vitamin.
- To involve different social segments, such as schools, in promoting healthy dietary practices through the spread of knowledge and recommendations concerning questions such as nutritional value, therapeutic properties, and the indication or prohibition of specific foods.
- To establish infrastructure and apply quality control measures to foods available for consumption, assuring their quality and germ-free status.
- To execute actions of sanitary supervision of foods under the municipality's supervision.
- To strengthen and maintain relations between sanitary supervision of food, the role of the SUS, and pertinent actions executed by the Ministry and State and Municipal Secretariats of Agriculture, with the aim of preserving attributes related to the nutritional value and healthfulness criteria of foods.
- To work together and form partnerships with other municipalities to better serve the population with regard to questions of food and nutrition.
- To participate in financing actions resulting from the State and National Policies, designating funds for the provision of services and the acquisition of foods and other materials and resources.
- To define and acquire, with the support of the other administrative jurisdictions, those foods and other strategic materials and resources needed for the healthcare network's distribution of food and nutritional supplements, assuring that necessary food and nutrition requirements are met and that supplies are adequate, regular and economical.

- To invest in the storage infrastructure of food and other materials and resources, for the purpose of maintaining their quality.
- To promote intersectorial negotiations that favor universal access to good quality food.
- To promote social control of the execution of this Policy, including the application of corresponding financial resources, by means of strengthening the action of the respective Municipal Health Council.

5. SUPERVISION AND EVALUATION

It is evident that the implementation of the guidelines and priorities delineated by the National Food and Nutrition Policy under the authority of the National Health System (SUS) requires a systematic and continual process of supervision and evaluation.

This process demands the definition of criteria, parameters, indicators and methodology, all directed in a specific and original way towards the evaluation of the Policy. Obviously, a large part of the information relevant to the supervision and evaluation process must originate from within the various plans, programs, projects and actions and/or activities that effect the realization of the National Policy.

Over and above the evaluation of questions related to the impact of extrasectorial food and nutrition policies or to food and nutrition themselves, this process aims at measuring both the Policy's repercussions on the health and quality of life of the population in general and the significance of its systemic intersectorial vision for the realization of the human rights aspect.

This evaluation process should include indicators that permit a confirmation of the extent to which the SUS principles and guidelines are being carried out, in accordance with the details of Art. 7, Law No. 8.080/90, observing, for example, whether:

- the population is sufficiently informed as to the nature of health services available and how to have access to them;
- the establishment of priorities, allocation of resources and orientation of programs are based on epidemiological evidence;
- the plans, programs, projects and activities that effectuate the National Food and Nutrition Policy are being developed in a decentralized way which considers the unique direction of each administrative sphere.

Additionally, the Policy evaluation process involves an appraisal of the fulfilment of the country's international agreements in the area of food and nutrition.

Prominent among these agreements are several initiated by diverse United Nations international agencies such as the FAO, the WHO and the UN High Commissioner for Human Rights, whose function it is to incorporate into government agendas concepts, objectives, goals and strategies related to food and nutrition.

Of the priority goals set for the year 2000, six refer to the area of food and nutrition, indicating its relevance as a field of action for governments and society. These goals are:

- to reduce to less than 10% the incidence of low birth-weight;
- to diminish by 50% the frequency of moderate and grave childhood malnutrition;
- to reduce by 1/3 the occurrence of gestational anemia;

- to control disorders provoked by iodine deficiency;
- to control vitamin A deficiency as a public health problem; and
- to provide conditions for all mothers to be able to exclusively breastfeed their children for the first six months of life, and to continue breastfeeding, along with the introduction of solid foods, until age two.

6. GLOSSARY

Anemia - Reduction of blood hemoglobin levels to below normal established limits for age, sex and physical condition.

Anthropometric deficit - Growth delays in the ratios of weight/age, weight/height and height/age, using as a reference conventionally recommended charts of averages. Can also refer to other indices of body measurements.

Anthropometric evaluation - The use of measurements – mainly height and weight – as a criterion for the evaluation of physical growth and, as an extension, nutritional state.

Baby-Friendly Hospital Initiative - Maternity and other hospitals that fulfil the “Ten Steps to Breastfeeding Success” endorsed by WHO/Unicef.

Bioavailability - The degree of utilization of specific nutrients contained in foods, using as a reference the total content – 100% - of the nutritive factor being considered.

Biological groups - See nutritional supervision, supervision of siblings and contacts, and vulnerability. Designates risks induced by biological factors.

Biological utilization of food - Process that involves the continuum digestion/absorption/metabolism/excretion, or partial resynthesis of foods in living organisms. Can be adversely altered by the occurrence of diseases at any one or more of the steps in the process.

Breastfeeding - The series of nutritional, behavioral and physiological processes that result in the child's ingestion, either directly at the breast or through artificial extraction, of milk produced by the mother herself.

Chemical-nutritional composition tables - Tables that provide information concerning the contents of foods in terms of proteins, fats, carbohydrates, vitamins and minerals significant to human nutrition.

Chronic malnutrition - Deprivational process of long duration, characteristically expressed in insufficient height.

Complementary diet (adequate and appropriate) - Feeding begun as a complement to breastfeeding between 4-6 months of age, providing a diet adequate in quantity and quality (nutrients and calories).

Complementary or transition foods - Those offered to the child between 4-6 months of age as a complement to mother's milk, beginning with pureed foods and gradually offering foods of greater consistency until the child can consume the regular family diet in addition to mother's milk. Currently, the term “weaning diet” is not used, to avoid giving the idea that introducing solid foods implies the suspension of breastfeeding.

Control of coexisting illnesses - Measures to prevent and cure the occurrence of illnesses that aggravate the nutritional state.

Cretinism - Mental retardation resulting from the adverse action of iodine deficiency on the maturation of the child's nervous system.

Diabetes - Process of glucose intolerance, usually resulting in an elevation in blood sugar and its eventual appearance in the urine.

Diet - Corresponds generically to individuals' food parameters. Specifically, it can represent a recommended combination of foods in determined proportions for therapeutic purposes.

Dietary orientation - Recommendations for the choice, preparation, domestic conservation and consumption of foods, by way of criteria which consider their nutritional values and specific indications according to physiological conditions (growth, pregnancy, lactation), pathologies (obesity, diabetes, nutrient deprivation) and, also, their socio-economic justification (nutritive value x cost). See healthy dietary practices.

Dietary traditions - Food uses and customs that are transmitted from generation to generation, according to the cultural traditions of particular ethnic or anthropologically homogeneous groups.

Dietary transition - Refers to the slow or rapid changes that occur in the child's eating patterns as breastfeeding is being substituted by other products in preparation for consumption of the normal family diet. A critical period for nutritional risk.

Dietetic products - Drinks or processed foods with characteristics such as low-calorie or reduced fat content, destined to the treatment of particular situations of medical or nutritional interest.

Dislipidemias - Term that refers to alterations, nearly always due to excesses, in the levels of lipids or fats, such as cholesterol and triglycerides, in the blood.

Endemic deprivation - Deprivation illnesses such as iron-deprivation anemia, energy-protein malnutrition and goiter, that appear with a regular and practically constant frequency, and a prevalence above the "normal" limits of tolerance.

Energy-protein deficiency - Also called energy-protein malnutrition, this refers to the nutritional state resulting from a deficiency of calories and proteins, occurring most frequently in children.

Epidemiological transition - Changes that occur in the morbidity-mortality profile of a population, describing the pyramid of demographic transition from a youthful population to one that is mature or elderly. The most characteristic epidemiological fact is the passage from the malnutrition/infection pole to the obesity/ chronic degenerative disease pole.

Exclusive breastfeeding - The use of mother's milk, usually until six months of age, as the child's sole source of nourishment, excluding even consumption of water or teas.

Food and nutritional security - Add to the definition of food security the concept that, beyond access to consumption, the organism must possess adequate physiological conditions for the utilization of the food through good digestion, absorption and metabolism of nutrients.

Food and nutritional surveillance - Consists of the collection and analysis of information concerning the food and nutritional situation of individuals and collectives, with the purpose of creating measures to prevent or correct existing or potential problems. An essential requisite for the rational justification of food and nutrition programs. See also growth and development, control of coexisting diseases and specific nutritional treatment.

Food assistance - See food support and food supplementation.

Food chain hazard - Biological, chemical or physical agent, or food property, that can have adverse effects on health.

Food composition - Nutritive value of foods or their content of specific substances such as vitamins, minerals and other elements.

Food enrichment - Addition of determined nutrients – vitamins, mineral salts and others – to foods with relatively low contents of those nutritive elements.

Foods “*in natura*” - Products offered and consumed in their natural state, without suffering industrial alterations that modify their physical-chemical properties (texture, composition, sensorial characteristics). Fruit and fresh milk are good examples of foods “*in natura*”.

Food security - Guarantee that families have regular and permanent physical and economic access to a basic food supply whose quantity and quality are sufficient to meet nutritional needs.

Food quality and safety - In Sanitary Surveillance, concerns those attributes related to safety and nutritional value of foods. See also healthy dietary practices.

Food quality guarantee - See food safety, sanitary surveillance of foods.

Food safety criteria - Principles and standards to assure that foods have good nutritional value and present no physical, chemical and biological contaminants harmful to consumers.

Food supplementation - Additional quota of foods destined towards prevention or correction of nutritional deficiencies. See food support.

Food support - Personal or institutional donations of one or more types of food for people suffering from, or at risk of, malnutrition. The same as food supplementation or, in some countries, food assistance.

Goiter - Significant enlargement of the thyroid gland, beyond normal limits.

Growth and development - The first term refers to the increase in body measurements, such as height and weight. The second is applied to the appearance and improvement of functions, such as language, motor ability, cognitive functions, psychic maturity and others.

Guardposts - Areas or communities that can be monitored by means of the application of a series of nutritional state indicators, providing information which, by analogy, can express the probable situation in similar socio-economic and sanitary contexts.

Healthy dietary habits - See healthy dietary practices, food quality and safety.

Healthy dietary practices - Uses, habits and customs that define parameters of food consumption according to scientific and technical knowledge concerning good nourishment. See dietary orientation, food composition, and nutritional well-being.

Human milk banks - Specialized centers responsible for promoting breastfeeding incentives and for the collection, processing, stocking and quality control of artificially extracted human milk, to later be distributed under a doctor's or nutritionist's prescription.

Human Poverty Index - This index is composed of indicators related to life expectancy, malnutrition in children under five, literacy, and access to health services and potable water.

Idiocy - Physical, motor and mental retardation brought about by grave iodine deficiency during the fetal period and the first months of life.

Insufficient height - Delay in growth in stature, when compared with the normal parameters for sex and age.

Intersectorial character - Aspect which considers the co-responsibility of two or more sectors of government in relation to the causes of or solutions to food and nutrition problems.

Iodine-dependent - Said of those functional or morphological disorders, among which are goiter and idiocy, produced by the deficiency of iodine in the water, salts and foods consumed.

Iron deficiency - Organic state of micronutrient deficit that occurs when dietary consumption of bioavailable iron is low, when blood losses are high or when requirement is increased due to infection or fever or, worse yet, when two or more of these conditions exist simultaneously, diminishing the body's stores of iron and resulting in the appearance of anemia.

Iron supplements - Organic or inorganic iron compounds used to treat anemia.

Low birth-weight - Cases of live births weighing less than 2500 grams.

Malnutrition - Generic term usually employed to distinguish nutritional deficiencies, referring mainly to energy-protein malnutrition. See the corresponding definitions for anthropometric deficit, energy-protein deficit and micronutrient deficiency which are specific cases of malnutrition or deprivation illnesses.

Mcg/dl - Micrograms per decilitres. Measurement used in laboratory exams.

Megadoses - Massive quantities of a medication or micronutrient administered in a single dose, as in the case of vitamin A.

Micronutrient deficiency - Organic state of lack of nutritive elements, such as vitamin A, iron, iodine and zinc, required by the body in very small quantities measurable in mg/day.

Micronutrients - Nutrients required by the body in extremely small quantities - milligrams or micrograms – such as iodine, vitamin A, zinc and iron.

Nourishment - Biological and cultural process involving the choice, preparation and consumption of one or more foods.

Nutrition - Physiological state that results from the consumption and biological utilization of energy and nutrients at the cellular level.

Nutrition-related diseases - Terminology for a great variety of diseases that result from insufficient consumption, excessive consumption or a prolonged imbalance between the ingestion and utilization of nutritive elements that should be harmoniously combined. Various other entries describe specific situations: goiter, malnutrition, nutritional deficiencies. See also dislipidemias and obesity.

Nutritional deficiencies - Situations in which general or specific deficiencies of energy or nutrients result in the installation of organic processes adverse to health.

Nutritional disorders - Health problems resulting from bad nutrition or, rather, pathological situations of nutritional etiology.

Nutritional labelling - Part of label that describes product's nutritional content.

Nutritional monitoring - Same as nutritional surveillance.

Nutritional risk - Conditions characterized by the increased possibility that a specific nutritional problem can occur, or may already be occurring.

Nutritional surveillance - A part of food and nutritional surveillance, having as its main focus the nutritional state of biological groups (children, pregnant women) and social groups (low-income) most susceptible to nutritional problems. Can also include the other pole (adult men and women with overweight, obesity and related problems).

Nutritional well-being - Organic state in which the functions of consumption and utilization of food energy and nutrients take place in accordance with the biological necessities of the individual.

Obesity - Exaggerated increase in weight in relation to height. The popular term for obese is fat.

Overweight - Excess of weight in an individual based on comparison with charts or standards of normality. Obesity is a more elevated degree of overweight.

Pharmaceutical products - The term is used in this document to designate pharmacological preparations in medication form that are based on specific nutrients, such as vitamins, iron, iodine, zinc, etc.

Primary iodine deficiency - Iodine deficiency initially attributed to insufficient ingestion of this micronutrient.

Prophylactic treatment - Treatment performed to prevent diseases or nutritional damages.

Sanitary surveillance of food - Supervises the application of standards and conducts that assure necessary food quality. See food safety criteria.

Specific nutritional treatment - Actions recommended by peculiar situations of nutritional risk, such as anemia, goiter, vitamin A deficiency and other conditions.

Stress - Adverse stimuli with different physical, psychic and nutritional impacts. Tension.

Supervision of siblings and contacts - Careful supervision along with the necessary treatments (food support or supplementation, growth evaluation, basic healthcare) for siblings and mothers (considered "contacts") of children between the ages of 6-23 months with malnutrition. Malnutrition in this age group can be indicative of malnourished mothers and siblings, constituting nutritional risk groups.

Therapeutic property - Property of a specific food or drug - see pharmaceutical products – to perform curatively in correcting deviations or fully characterized illnesses, as in the case of nutrition-related illnesses.

Therapeutic treatment - Treatments adopted to correct clinical pathological situations. Actions destined toward curing diseases.

Vitamin A deficiency - Low vitamin A availability in hepatic deposits and diminished levels in the blood; may or may not present signs and symptoms of the deficiency.

Vitamin A precursors - Substances contained in plant foods – carotenes – that convert to vitamin A after being ingested.

Vulnerability - Deals with the biological, occupational or social factors that increase the risks of nutritional damages.

Weaning - Process that begins with the introduction into the child's diet of any food element other than breastmilk, including water and teas, and ends with the complete suspension of mother's milk.

Weight/age deficit - The explanation is implicit in the terminology of anthropometric deficit.

Weight/age ratio percentiles - Percentile refers to the position of an individual in a given distribution of reference. Thus, the tenth and third percentiles, as used in the text, refer to those values of weight presented by, respectively, 10% and 3% of the children in the distribution of the anthropometric parameters of reference. In this way, a child whose weight is equal or inferior to these two limits has a greater possibility of presenting a nutritional disorder. In other words, it can be affirmed that the tenth or third percentile of weight/age ratio is the dividing line represented graphically on the official growth charts, indicating the lowest point of separation between normality and possible malnutrition or insufficient growth. Visualization of the chart clarifies well the principle and application of tenth percentile and third percentile.

Xerophthalmia - Ocular alterations resulting from vitamin A deficiency.

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