MINISTRY OF HEALTH OF BRAZIL

National Food and Nutrition Policy

Brasilia – DF

2013

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SUMMARY

PRESENTATION

The National Food and Nutrition Policy (PNAN), approved in 1999, integrates the efforts of the Brazilian State, which through a set of public policies determines to respect, protect, promote and provide human rights for health and nutrition.

The Brazilian population, in recent decades, has undergone major social transformations that have resulted in changes in their standards of health and food consumption. These transformations have caused an impact on reducing poverty and social exclusion, and consequently hunger and malnutrition. On the other hand, there has been a steep increase in overweight in all segments of the population, pointing to a new set of problems related to food and nutrition.

Upon completion of ten years of publication of PNAN, a process of updating and improving its bases and guidelines was started in order to consolidate the policy as a reference for the new challenges to be faced in the field of Food and Nutrition within the Unified Health System (SUS).

In partnership with the Intersectoral Committee for Food and Nutrition (CIAN) of the National Health Council, the Ministry of Health conducted a broad and democratic process of updating and improving the policy through 26 State Seminars and the National Seminar on Food and Nutrition - PNAN 10 years, which included the presence of state and local health counselors, civil society organizations, health worker associations, state and municipal

Nutrition and Primary Health Care managers, state councilors of Food and Nutrition Security, Collaborating Centers for Food and Nutrition associated do universities and experts in public policies of health, food and nutrition.

In this new edition, the National Food and Nutrition Policy (PNAN) is presented with the purpose of improving food, nutrition and health conditions, in order to guarantee food and nutritional safety for the population. It is also organized into guidelines that encompass the scope of nutritional care in the Unified Health System, focused on surveillance, promotion, prevention and comprehensive care for health problems related to food and nutrition. These activities are integrated to the other initiatives in the health care networks, with Primary Health Care as the organizer of the initiatives.

Brasilia, November 17, 2011

Ministry of Health

ORDINANCE NO. 2,715 OF NOVEMBER 17, 2011

Updates the National
Food and Nutrition Policy.

The STATE MINISTER OF HEALTH, in using the powers granted to them in items I and II of the sole paragraph of art. 87 of the Constitution, and

Considering Ordinance No. 2.488/GM/MS of October 21, 2011, which approves the National Primary Health Care Policy;

Considering Ordinance No. 154/GM/MS of 24 January 2008, which establishes the Centers for Family Health Support - NASF;

Considering Ordinance No. 2.246/GM/MS of October 18, 2004, which establishes and disseminates basic guidelines for the implementation of Food and Nutrition Surveillance Initiatives under the basic health initiatives of the Unified Health System - SHS, throughout the country;

Considering Interministerial Ordinance No. 1010 of May 8, 2006, which establishes guidelines for the Promotion of Healthy Food in Elementary, Middle and High Schools in the public and private systems nationwide;

Considering Ordinance No. 687/GM/MS of 30 March 2006, which approves the National Health Promotion Policy.

Considering Ordinance No. 4.279/GM/MS of 30 December 2010, which establishes guidelines for the organization of the Health Care Network under the Unified Health System;

Considering the need for the health sector to have a duly explicit policy related to food and nutrition, in line with the promotion of food and nutrition security and which contributes to guaranteeing the right to food;

Considering the completion of updating the policy, which involved consultations with different segments directly and indirectly involved with the subject, and

Considering the approval of the proposed update of the policy mentioned by the Tripartite Commission, resolves to:

Article 1 Approve the National Food and Nutrition Policy, which is available in its entirety at the electronic site http://nutricao.saude.gov.br.

Article 2 Determine the organs and entities of the Ministry of Health, whose initiatives are related to the topic which is the subject of the policy now approved, promote the development or the readaptation of its plans, programs, projects and activities in compliance with the guidelines and responsibilities stated therein.

Article 3 This Ordinance shall enter into force on the date of its publication.

Article 4 Ordinance No. 710/GM/MS of June 10, 1999, published in Official Gazette - DOU of 11 June 1999, section 1, page 14, is repealed.

ALEXANDRE ROCHA SANTOS PADILHA

1 INTRODUCTION

Food and nutrition are basic requirements for the promotion and protection of health, enabling the full potential of human growth and development, with quality of life and citizenship.

The Brazilian population in recent decades has undergone major social transformations that have resulted in changes in their standards of health and food consumption. These changes have caused an impact on reducing poverty and social exclusion, and consequently hunger and food shortages, improving the access to and variety of foods, as well as ensuring the average availability of calories for consumption, although there are still nearly 16 million Brazilians living in extreme poverty. The reduction of hunger and malnutrition has been accompanied by a sharp rise in obesity in all segments of the population, pointing to a new set of problems related to food and nutrition.

Food and nutrition are included in recent legislation of the Brazilian State, with an emphasis on Law 8080 of 19.09.1990 (BRAZIL, 1990), which understands food as a conditioning and determining factor in health and that food and nutrition initiatives should be carried out transversely to health care initiatives, in a complementary way and with their formulation, execution and evaluation within the activities and responsibilities of the health system.

In the last decade, the main achievement was the incorporation of food as a social right. Constitutional Amendment No. 64, approved in 2010, introduced food as a right in Article 6

of the Constitution (BRAZIL, 2010). Along these lines, the Brazilian State, enrolled in building a new approach to combat hunger, poverty and to promote adequate and healthy nourishment, published Law 11.346/2006 - the Organic Law for Food and Nutrition Security (BRAZIL, 2006a) and Decree 7272/2010 - National Food and Nutrition Security Policy (BRAZIL, 2010b). Both the law and the Decree introduce among their base guidelines the strengthening of food and nutrition initiatives in the health system.

In the health field, we must also emphasize the publication of Decree 7508 of 6/28/2011, which regulates Law 8080 with the establishment of the Health Care Network and Clinical Protocols and Therapeutic Guidelines that will enable advances in organizing and offering Food and Nutrition initiatives under SUS (BRAZIL, 2011a).

Other health policies are added to the PNAN principles and guidelines in establishing Health and Food and Nutrition Security. The National Primary Health Care Policy and National Health Promotion Policy are oriented accordingly.

The social determinants of health as well as health promotion and the prevention of health problems are included in various known international documents such as the Report of the National Commission on Social Determinants of Health, published in 2008, the Global Strategy for Infant and Young Child Feeding (2002) and the Global Strategy on Diet, Physical Activity and Health (2004). The documents point to the need for formulating and implementing effective and integrated national, local and regional strategies for

reducing morbidity and mortality related to inadequate diet and a sedentary lifestyle, with recommendations and information tailored to the different realities faced by the countries and integrated with their policies, in order to guarantee individuals the ability to make healthy choices regarding nutrition and physical activity, and anticipate regulatory, fiscal and legislative initiatives designed to make such choices feasible for the population.

Breastfeeding, which should be the first feeding practice of individuals, is necessary to guarantee the health and development of children. Brazil has adopted international guidelines recommending exclusive breastfeeding up to six months and continued breastfeeding into the second year of life. According to the National Demographics and Health Survey (PNDS), conducted in 2006, 95% of Brazilian children have been breastfed, but that number drops dramatically over the first two years of life (BRAZIL, 2009). According to the Second Survey on the Prevalence of Breastfeeding in Brazilian capitals and the Federal District, carried out in 2008, the median duration of exclusive breastfeeding was 54 days and the median of total breastfeeding, which should be 24 months, was 341.6 days (11.2 months) (BRAZIL, 2009c). Currently, according to the survey, the prevalence of exclusive breastfeeding in infants under six months is 41%.

The transition from breastfeeding to foods consumed by family is the period known as complementary feeding, which should begin at six months and end at 24 months. The introduction of food should be done in a timely manner in adequate quantity and quality for each stage of child development. This is time when

early habits are acquired and formed and the correct introduction of foods plays a role in promoting health and healthy habits as well as protecting the child from micronutrient deficiencies and chronic diseases in adulthood. According to PNDS, early introduction of food, before two months of age, used to be a practice in 14% of children, evolving into more than 30% in children between four and five months (BRAZIL, 2009a).

The regular diet of Brazilians is composed of various influences and is now strongly characterized by a combination of a diet known as "traditional" (based on rice and beans) with food classified as ultra-processed, with high levels of fat, sodium and sugar, low in micronutrients and high in caloric content. The average consumption of fruits and vegetables is still only half the amount recommended by the Dietary Guideline for the Brazilian Population and has remained stable over the last decade, while the consumption of ultra-processed foods such as sweets and soft drinks, has increased every year.

Differences in income are apparent in the pattern of food consumption among different strata. The diet of lower-income Brazilians is better in quality, predominantly rice and beans combined with staple foods as fish and corn. The frequency of low nutritional quality foods such as sweets, soda, pizza and fried and baked snacks, tends to grow with the increase in family income.

Consumption patterns also vary according to age groups. Among the youngest, consumption of ultra-processed foods is higher,

which consumption tends to decrease with age, while the opposite is observed with fruits and vegetables. Teenagers are the group with the worst dietary profile, with the lowest consumption of beans, salads and vegetables in general, pointing to a prognosis of increase in overweight and chronic diseases.

Brazilians who live in rural areas, compared with residents of urban areas, have a higher consumption of staple foods with a better quality diet, and consume more foods such as rice, beans, sweet potatoes, manioc, manioc flour, fruit and fish. In urban areas, there is a higher consumption of ultra-processed foods. Geographic regions also print their food identity, with the northern region consuming more manioc flour, açaí and fresh fish; in the northeast more eggs and crackers; in the central west more rice, beans, beef and milk; in the southeast and south more French bread, pasta, potatoes, cheese, yogurt and soft drinks. In some regions cultural traditions resist change, while in others these traditions are losing their character with the loss of a cultural food identity.

The current life style favors a greater number out-of-home meals: in 2009, 16% of calories were derived from food outside of the household. This consists, in most cases, of industrialized and ultraprocessed foods such as soft drinks, beer, sandwiches, salty snacks and industrialized snacks, determining an eating pattern that is often repeated at home.

This nutritional transition has been accompanied by an increase in the average availability of calories for consumption.

In 2009 the average daily energy consumption of the population was higher than the recommended 2000 kcal, which is another contributing factor to the increase in overweight. This average resembles those found in developed countries such as the United States, which has the highest averages among male adolescents and lowest among the elderly.

The decline in the amount of physical activity, combined with the adoption of unhealthy eating habits, adhering to standard of diet rich in foods with high energy density and a low concentration of nutrients, increased consumption of ultra-processed foods and excessive intake of nutrients such as sodium, fat and sugar are directly related to the increase in obesity and other chronic diseases such as diabetes and hypertension, and explain part of the increasing prevalence of overweight and obesity observed in recent decades.

Regarding diseases related to micronutrient deficiencies, the National Survey of Demographics and Children's and Women's Health, carried out in 2006, reaffirmed that deficiencies of iron and vitamin A still persist as public health problems in Brazil: 17.4% of children and 12.3% of women of childbearing age have vitamin A deficiency, while 20.9% and 29.4% of those population groups, respectively, have iron deficiency anemia. Regional studies indicate an average prevalence of nearly 50% of iron deficiency anemia in children under five years old.

The improvement in access to the health and income of the population should have had an impact on the indicators of

micronutrient deficiencies, deficiencies that apparently had been resolved, as in the case of vitamin A and other deficiencies, such as the resurgence of cases of beriberi in some Brazilian states, and the imbalance of iodine intake by adults from excessive consumption of iodized table salt.

Brazilian society has undergone a peculiar and rapid nutritional transition: from a country with high rates of malnutrition in the 1970s, it became a country with half the adult population overweight in 2008. The reduction of malnutrition in children under age five has been significant in recent decades. Along these lines, the combination of economic and social policies, particularly in the 2000s, has been crucial to Brazil to progress in reducing internal inequalities. From 1989 to 2006, Brazil achieved the goals regarding childhood malnutrition of the first Millennium Development Goal (MDG indicator for the eradication of extreme poverty and hunger): The prevalence of underweight children (under age five) dropped more than four times (from 7.1% to 1.7%), while stunting deceased to about one-third during the same period (from 19.6% to 6.7%). However, progress has been uneven. A persistent high prevalence of chronic malnutrition in vulnerable population groups, as among indigenous children (26%), quilombolas (descendants of Brazilian slaves) (16%), residents of the country's northern region (15%) and those belonging to families benefiting from cash-transfer programs (15%), affecting mainly children and women living in poverty areas. Despite the differences among ethnic groups and geographic regions, the greatest reduction in the prevalence of child malnutrition occurred in the northeast and in the country's poorest populations,

with the main factors responsible for these developments: increased maternal education, increased family income, greater access to the primary health care network and the expansion of basic sanitation.

At the same time, Brazil has been facing a significant increase in overweight and obesity, just as in various countries around the world. Because of its magnitude and speed of evolution, excess weight – which includes overweight and obesity – is now considered a major public health problem, affecting all age groups. In twenty years, the prevalence of obesity in children aged 5-9 has quadrupled for boys (4.1% to 16.6%) and quintupled for girls (2.4% to 11.8%). In adolescents, after four decades of a gradual increase in prevalence, nearly 20% were overweight (with little difference between the sexes) and almost 6% of adolescent males and 4% of females were classified as obese.

In the adult population, there has been an increase in overweight and obesity in all age and income brackets. Obesity has grown from 2.8% in men and 7.8% in women to 12.5% among men and 16.9% among women between 1974-1975 and 2008-2009, so that excessive weight has reached 50.1% in men and 48.0% in women. Currently, obesity is similarly prevalent among women of all income levels, but among men, obesity among the wealthiest twenty percent of the population is twice as prevalent as among the poorest quintile. The average income of the Brazilian population has increased in recent decades, and chronic diseases related to obesity have begun to show similar rates between the groups.

Chronic diseases are the leading cause of adult mortality in Brazil. In recent years, the percentages of hypertension and diabetes have been stable, while obesity is on the rise. According to VIGITEL, obesity progresses each year about 1% among adults. The increase in obesity is strongly linked to food intake and physical activity. Its determinants are demographic, socioeconomic, epidemiological and cultural, in addition to environmental issues, which make obesity a multifactorial disease. These factors interact in complex ways, requiring obesity to be treated considering all its complexity and social determination. The Study of the Global Burden of Disease in Brazil reveals that 58% of the years of early loss of life are due to chronic diseases.

Health and nutrition indicators reflect inequalities in income and race that still persist in Brazil: black women with low income have higher rates of chronic diseases when compared with white women of the same age and higher income. Among men, obesity is more prevalent among those with higher income, although it is growing in all groups.

Economic development must be accompanied by the health sector so that income increase is also followed by improved access to health and better health conditions.

The epidemiological scenario presented reflects the advances in Brazil in the fighting hunger and malnutrition, although there are still populations that are vulnerable to these diseases. The accelerated growth of overweight in all age and income groups stresses the need for measures to control and prevent weight gain.

If these initiatives are not implemented, it is estimated that in twenty years nearly 70% of Brazilians will be overweight in Brazil.

Tackling this situation calls for action in various sectors, from production to the commerce of food and guaranteeing environments that facilitate behavioral change in individuals and society. Aware of its sanitary responsibility dealing with this scenario, the PNAN constitutes a timely and specific answer from SUS to reorganize, qualify and improve their initiatives to cope with the complexity of the Brazilian population's food and nutrition situation, while it promotes adequate and healthy diets and nutritional care for all stages of life.

2 OBJECTIVE

The purpose of the National Food and Nutrition Policy (PNAN) is to improve the diet, the nutrition and the health of the Brazilian population by promoting healthy and adequate eating habits, food and nutrition surveillance, and the prevention and comprehensive care of diseases related to food and nutrition.

3 PRINCIPLES

PNAN's pretexts are the rights to Food and Health and it is guided by the doctrinal and organizational principles of the Unified Health System (universality, comprehensiveness, equity, decentralization, regionalization and hierarchization and popular participation), to which are added the following principles:

Diet as an element of humanization in healthcare practices: food expresses the social relations, values and history of the individual and of population groups and has direct implications for the health and quality of life. The relational approach to food and nutrition contributes to the series of practices offered by the health sector in valuing human life beyond the biological condition and the recognition of its centrality in the process of producing health.

Respect for diversity and food culture: Brazilian food, with its regional particularities, is the synthesis of the historical process of cultural exchange among the indigenous, Portuguese and African origins that are added, through migration, to the influences of practices and knowledge of other peoples about food that make up the Brazilian socio-cultural diversity. To recognize, respect, preserve, retrieve and disseminate the immeasurable richness of food and eating practices corresponds to developing initiatives based on the respect for the population's identity and food culture.

The strengthening of individual autonomy: strengthening or expanding the stage of autonomy for food choices and eating habits implies, on one hand, and increased capacity for interpreting and

analyzing themselves and the world by the subjects and, secondly, the ability to make choices, to govern and produce one's own life. Therefore, it is important for the individual to develop the ability to handle situations from knowledge of the determinants of the problems that affect him/her, and face them with critical reflection. Given the interests and pressures of the commercial food market, as well as the rules of discipline and the prescribing of dietary behavior in the name of health, having more autonomy means knowing various perspectives, being able to experience, decide, reorient, expand the objects of investment related to eating and being able to count on people in these choices and movements. There is a fine line between pleasure and harm that must be continually analyzed, because it often leads health professionals to place themselves on the extremes of omission and the exacerbated governing of others. Along these lines, we must invest in communication tools and strategies and in health education that supports health professionals in their role of socializing knowledge and information about diet and nutrition and to support individuals and communities in the decision for practices that promote health.

Social determination and the interdisciplinary and intersectoral nature of food and nutrition: the knowledge of socioeconomic and cultural determinations of food and nutrition of individuals and communities contributes to building means of access to adequate and healthy nourishment, working with change in the production model and consumption of foods that determine the current epidemiological profile. The search for comprehensiveness in nutritional care requires cooperation among the various social sectors and constitutes a

possibility of overcoming the fragmentation of knowledge and social and institutional structures in order to respond to problems with food and nutrition experienced by the population.

Food and nutritional safety with sovereignty: Food and Nutritional Safety (SAN) has been established in Brazil as the realization of everyone's right to regular and ongoing access to quality food in sufficient quantities, without compromising access to other essential needs, being based on eating practices that promote health and respect cultural diversity and that are environmentally, culturally, economically and socially sustainable. Food Sovereignty refers to the right of people to decide their own system of eating and producing food that is healthy and culturally appropriate and accessible, in a sustainable and environmentally friendly way, placing those who produce, distribute and consume food at the heart of food systems and policies, above market demands.

4 GUIDELINES

The guidelines that make up PNAN indicate various initiatives to achieve its purpose that are capable of modifying the determinants of health and promote the population's health. These are consolidated into:

1. Organization of Nutritional Care
2. Promotion of Adequate Healthy Eating
3. Food and Nutrition Surveillance
4. Management of Food and Nutrition Actions
5. Social Participation and Control
6. Qualification of the Workforce
7. Food Control and Regulation
8. Research, Innovation and Knowledge in Food and Nutrition
9. Cooperation and Articulation for Food and Nutrition Security

4.1 Organization of Nutritional Care

The current food and nutrition situation in the country stresses the need for better organization of health services to meet the demands created by health problems related to poor diet, both in relation to diagnosis and treatment and related to for disease prevention and health promotion. Also included are surveillance initiatives to identify their determinants and conditionants, as well as the most vulnerable regions and populations.

Thus, nutritional care includes the care related to food and nutrition aimed at promoting and protecting health, and the prevention, diagnosis and treatment of diseases, and should be

associated with other SHS health care initiatives for individuals, families and communities, and contribute to the establishment of an integrated, resolvent, humanized care network.

The subjects for nutritional care are individuals, families and community. Individuals have specific characteristics and the elements of their diversity are the phase of life they are in, in addition to the influence of the family and community in which they live. All phases of life should be the focused by nutritional care, however it is important to identify and prioritize the phases that are most vulnerable to diseases related to food and nutrition.

Families and communities must be understood as "collective subjects" that have different characteristics, dynamics, organization forms and needs, just as they have different responses to factors that may affect them. The specificities of different population groups, traditional peoples and communities, such as blacks, quilombolas and indigenous peoples, among others, as well as the specifics, should also be considered.

Nutritional care must be a part of the comprehensive care of the Health Care Network, having primary health care as a coordinator of care and organizer of the network. Primary Health Care, because of its capillarity and ability to identify the health needs of the population under its responsibility, contributes to the organization of nutritional care based upon to the needs of users.

To this end, the process of organizing and managing care relating to food and nutrition in RAS should be initiated through the diagnosis of the food and nutrition situation of the population

assigned to the Primary Health Care services and teams. Food and nutrition surveillance will enable ongoing evaluation and organization of nutritional care in SHS, identifying priorities according to the food and nutritional profile of the assisted population.

For this diagnosis the System of Food and Nutrition Surveillance (SISVAN) and other health information systems should be used to identify individuals or groups who have health problems and risks related to their nutritional status and food consumption. In order to identify possible determinants and conditionants of the population's food and nutrition situation, it is important for Primary Health Care teams to include, in their territorialization process, the identification of locals where foods are produced, commercialized and distributed and local food habits and traditions, as well as other characteristics of the territory where the population lives, which may relate to their eating habits and nutritional status.

Nutritional care should prioritize the implementation of initiatives in the context of Primary Health Care, but must include, according to the needs of users, other points of health care, such as diagnostic and therapeutic support services, specialized services, hospitals and home care, among others in SUS. Initiatives in different social facilities (governmental or not) that may contribute to comprehensive health care through intersectoral cooperation should also be considered.

In this context, the practices and processes of receiving the population need to consider food and nutrition as health determinants and take into account the subjectivity and complexity of the eating

behavior. This implies disseminating these ideas among professionals, contributing to qualifying their listening and problem-solving capacities in a humanized perspective. Other rationales should be considered in nutritional care organization, allowing the incorporation of integrative and complementary practices in food and nutrition care in the Unified Health System.

In the context of Primary Health Care, nutritional care respond to the demands and health needs of its territory, taking into consideration those of higher frequency and relevance and observing risk and vulnerability criteria. Given the country's current epidemiological situation, initiatives for preventing and treating obesity, malnutrition, specific nutritional deficiencies and chronic diseases related to food and nutrition are a priority. The care of individuals with special dietary needs, such as those resulting from innate metabolism errors, sickle cell disease and eating disorders, among others, also demand nutritional care in the Unified Health System.

For practicing nutritional care in the arena of Primary Health Care, reference teams should be supported by multidisciplinary teams through a matrix-based process and amplified clinic, with the participation of professionals from the food and nutrition area who will empower other professionals to develop comprehensive initiatives in this area, while respecting their core competencies.

Preventive initiatives for specific nutritional deficiencies by supplementing micronutrients (iron, vitamin A, among others) are the responsibility of Primary Health Care services in accordance with the

technical standards of the supplementation programs. Maternity hospitals collaborate in the implementation of micronutrient supplementation programs, particularly in supplementing vitamin A to mothers in the postpartum period.

Although Primary Care is the preferred front door to the health system, the demands for nutritional care can be identified elsewhere in the Health Care Network. Thus, nutritional care at other points of health care should also be performed within an integrated health care network to crosscut other specific policies and with the participation of multidisciplinary teams, respecting the particular activities of their professionals, as well as in Primary Health Care. Therefore protocols, manuals and technical standards that guide the organization of care relating to food and nutrition in the Health Care Network need to be developed. Criteria for accessing foods for special purposes should also be standardized in order to promote equity and regulation in the access to these products .

In the hospital field, it is necessary to promote coordination between clinical and nutritional monitoring, in view of the importance of nutritional status to the clinical evolution of patients, as well as its interaction with the services of preparing meals and nutritional therapy services, understanding that the provision of adequate and healthy nourishment is a key component in the process of recovering health and preventing new health problems in hospitalized patients.

In the context of guaranteeing the provision of adequate and healthy nourishment, the importance of the Health Care Network

as a support network for breastfeeding and complementary healthy food must be emphasized. In order to accomplish this, the practice of breastfeeding (exclusively up to the 6th month and supplementary to 2 years) and the donation of human milk in various health services in coordination with Human Milk Banks, to increase the supply of breast milk in cases of maternal and infant health problems that preclude the practice of breastfeeding, must be encouraged and facilitated.

The organized and progressive incorporation of nutritional care should have a positive impact on the population's health.

4.2 Promotion of Adequate and Healthy Nourishment

Adequate and healthy eating is understood as the dieatary practice that is appropriate to the biological and sociocultural aspects of individuals as well as to a sustainable use of the environment. Thus, it must be in accordance with the needs of each phase of life and with special dietary needs; referenced by food culture and by gender, race and ethnicity; accessible from a physical and financial standpoint; harmonious in quantity and quality; based on adequate and sustainable production practices; with minimum quantities of physical, chemical and biological contaminants.

The Promotion of Adequate and Healthy Eating (PAHE) is one of the aspects of Health Promotion. Within the Unified Health System, the health promotion strategy is resumed as a possibility for focusing on factors that determine the health-disease process in our country. Thus, initiatives for health promotion consist of broader ways

of intervention in the conditions and social determinants of health through an intersectoral approach and with the participation of the people, favoring healthy choices by individuals and communities in the territory where they live and work.

Here PAHE is understood as a set of strategies that allows individuals and communities to accomplish eating practices that are suitable to their biological and sociocultural aspects, as well as with sustainable use of the environment. Is must be also considered that food has functions that transcend the fulfilling the biological needs, because it includes singular cultural, behavioral and affective meanings that cannot be neglected.

The implementation of this guideline of the Policy is based on the dimensions of incentive, support, protection and promotion of health and should combine initiatives focused on (i) healthy public policies, (ii) the creation of health-enabling environments where individuals and communities can exercise healthy behaviors, (iii) strengthening community action, (iv) the development of personal skills through ongoing participatory processes, and (v) the redirection of services by the perspective of health promotion.

In this context, PAHE intends to improve the population's quality of life through intersectoral initiatives focused on the collectivity, on individuals and on environments (physical, social, political, economic and cultural), in the broad sense, and which can respond to the population's health needs, contributing to reducing the prevalence of overweight and obesity, associated chronic diseases and others diseases related to food and nutrition.

The set of health strategies aimed to PAHE encompasses food and nutrition education added to food regulation strategies (involving labeling and information, publicity and improvement related to the nutritional profile of foods), and incentives to create institutional environments that promote adequate and healthy nutrition, focusing on the provision of healthy food in schools and workplaces. The supply of healthy foods should also be encouraged among the small food and meal businesses known as "street food".

Therefore, the commitment of health sector to the articulation and development of intersectoral initiatives in different governmental spheres and with society is assumed. Organizing PAHE initiatives involves developing mechanisms to support individuals to adopt healthy lifestyles and identify and analyze critically, as well as to confront the habits and practices that do not promote health to which they are often subjected.

The development of personal skills in food and nutrition implies thinking of food and nutritional education as a process of dialogue between health professionals and the public, which is fundamental for the exercise of autonomy and selfcare. This presupposes, above all, working with practices in the local context, both problematic and constructive, taking the contrasts and inequalities into account that affect the universal right to food. To do this, a priority is the drafting and negotiation of an integrated agenda - intra and intersectoral - of food and nutritional education for developing individual and collective capacities in various sectors related to the topic.

The responsibility of health teams in relation to PAHE should transcend the boundaries of health units and introduce themselves into other social facilities such as community spaces for physical activity and body practices, schools and day-care centers, community associations, social networks and work environments, among others.

The PAHE series of initiatives, combined with other initiatives to promote health, contributes to expanding the scope of health initiatives, stimulating innovative and socially contributory alternatives to develop individuals and communities, overcoming the biomedical model which is guided by disease, and challenges such as (i) the approach that is limited to the production and supply of technical and scientific information, (ii) the fragile integration of scientific knowledge and popular knowledge, and (iii) insufficient appropriation of cultural and social dimensions as determinants of dietary habits.

Because of the nature of the PAHE initiatives, popular participation is essential and should take place since diagnosing the situation and setting goals to implement initiatives, reflected in the discussions led in the spaces of social participation and control. Thus, incorporating the dimension of adequate and healthy eating in the contents and strategies of social movements for popular eduction on health and training for participatory management in control instances of the SUS should be encouraged. Besides social mobilization, the participation of public and private sectors in developing and implementing strategies should be considered.

4.3 Food and Nutrition Surveillance

Food and nutrition surveillance consists of a continuous description and prediction of trends in the population's food and nutrition conditions and their determinants. It should be considered from an expanded approach that incorporates surveillance in health care services and integrates information from health information systems, population surveys, health and nutrition day surveys and scientific production.

It should provide disaggregated data for different geographical areas, categories of gender, age, race/ethnicity, special populations (such as indigenous peoples and traditional communities) and others of interest to a broad understanding of the population's food and nutrition diversity and dynamics. Its institutional strengthening will allow documenting the distribution, magnitude and trends of nutritional transition, identifying its outcomes and social, economic and environmental determinants.

Food and nutrition surveillance will subsidize planning nutritional care and initiatives related to health promotion, to adequate and healthy eating and to food quality and regulation in the management arenas of the Unified Health System. It will also contribute to social control and participation and to the diagnosis of food and nutrition security within the territories.

The main objective of the Sisvan (Food and Nutrition Surveillance System), operated from Primary Health Care, is to

monitor the dietary patterns and nutritional status of individuals served by the Unified Health System in all stages of life. It should support health professionals in a local and timely diagnosis of dietary and nutritional problems and in gathering food consumption markers that can identify risk or protective factors, such as breastfeeding and the introduction of complementary feeding.

Attention should be given to food and nutrition surveillance of traditional peoples and communities and population groups in conditions of vulnerability and inequity.

Monitoring of the nutritional and health status of people assisted by cash-transfer programs should be incorporated into Sisvan in order to enhance the efforts of the health teams and qualify the information and nutritional care given to these families.

From the perspective of integrating and organizing indigenous health and seeking to overcome the extreme nutritional vulnerability of these populations, and food and nutrition surveillance, integrating and operating the existing information systems, should be emphasized.

A broad diagnosis in territories under the responsibility of Primary Health Care requires the analysis of nutrition surveillance data along with other information on natality, morbidity, mortality, coverage of programs and health services, among the others available in different health information systems.

Food and nutrition surveillance should contribute to other government sectors, in order to monitor the dietary patterns and nutritional indicators which are part of the set of information for Food and Nutrition Security surveillance.

Child nutritional surveys, such as Health and Nutrition Day Surveys, are cross-sectional surveys held on strategic dates - such as "national immunization day" - enabling studies on aspects of children's diet and nutrition, as well as cash-transfer and food access social policies targeted to vulnerable populations. These surveys should be implemented at different levels, from local to national.

In the field of population surveys, it is essential to ensure regular and ongoing surveys that address household food availability, individual food intake and the nutritional status of the Brazilian population, such as the Household Budget Surveys, conducted by the National Institute of Geography and Statistics (IBGE). Regular surveys on maternal and children health and nutrition, such as the National Demographics and Health Surveys (DHS), should also be guaranteed.

In order to support health management, food and nutrition indicators must be strengthened in the systems which monitor the population's health situation, including health situation rooms and the establishment of information centers on food and nutrition, emphasizing their use in the planning tools and negotiations in the Unified Health System.

4.4 Management of Food and Nutrition Actions

The PNAN, in addition to representing a political and normative reference for the realization of the rights to food and health, represents a strategy that combines two systems: the Unified Health System, its institutional place, and the Food and Nutritional Security System (SISAN), a space for intersectoral articulation and coordination.

Its transversal nature to the other health policies and its eminently intersectoral character create the challenge of coordinating a common food and nutrition agenda with other government sectors and its integration with other policies, programs and initiatives of the Unified Health System. Thus, its managerial structures should enable building strategies to develop and implement processes, procedures and management flow in line with organizational realities and which promote the formulation, implementation and monitoring of their food and nutrition actions.

The Unified Health System managers at the federal, state, district and municipal levels are responsible for promoting the implementation of PNAN through the facilitation of partnerships and the inter-institutional coordination needed to strengthen its convergence with Health and Food and Nutrition Security Plans.

The improvement of planning and evaluation processes for the food and nutrition actions must be encouraged in order to support negotiations and incorporating the actions into the managerial tools. The negotiations between the government levels to actualize the

PNAN must comply with all rules and instances practiced in the Unified Health System, so that actions can be assumed and incorporated by the managers of the three government levels in the context of the Health Care Network and, therefore, can be consolidated around the country.

In order to achieve the improvement in the population's food and nutrition conditions, it is necessary to guarantee strategies of tripartite funding strategies to implement the PNAN guidelines, with the following priorities:

- The acquisition and distribution of supplies for prevention and treatment of specific nutritional deficiencies;
- The adaptation of the equipment and physical structure of health services to carry out the food and nutritional surveillance actions;
- The guarantee of continuous education in food and nutrition for health workers;
- The guarantee of appropriate work processes for the organization of nutritional care in the Unified Health System.

In the field of International Cooperation, the trajectory of Brazilian public policies of food and nutrition and of food and nutrition security can contribute to the solidary development of nutrition policies in other countries. In order to implement this, principles of the human right to food, of sovereignty and of food and nutrition security must be incorporated into Brazil's foreign policy in the scope of agreements and mechanisms of international cooperation.

Also, the PNAN contributes along with other initiatives of the Ministry of Health to strengthen international cooperation relations, with a focus on countries that comprise the South/South relationships, especially at the regional level in Mercosul, Latin America and the Caribbean. Special attention should be given to African countries where the official language is Portuguese (so called, PALOPS).

The work of the Ministry of Health together with UN Agencies such as the United Nations Standing Committee on Nutrition (SCN), the Pan American Health Organization and the Food and Agriculture Organization Food Security Committee, should be encouraged to collaborate in building recommendations and global development goals related to food and nutrition.

The proposal and guidelines of this policy reveal the need for a continuous process of monitoring and evaluation of its implementation. Monitoring and evaluation of the PNAN management should focus on improving the policy and its implementation in the levels of the Unified Health System. Its objective is to verify the impact of this policy on the population's health and quality of life, seeking the characterization and understanding of a situation for decision making, as well as to propose criteria and standards that directly affect the performance of the policy and its indicators at different levels of action.

To this end, building the monitoring of the PNAN actions starts by identifying the production and processes developed by the federal government, added, at each level, of their own specific processes of apprehending and adapting the guidelines issued by national policy.

This should take into account the prioritized nutritional problems, and the participation and access of the population to PNAN programs and actions. This process will require defining priorities, objectives, strategies and goals for nutritional care.

The evolution of accompaniment to a tripartite and participatory monitoring system for the PNAN, which considers the dimensions of respect for people's rights and the adequacy of services provided, will be in line with the Unified Health System planning and negotiation systems.

When enabling this assessment, indicators that allow verifying to what amount the principles and guidelines of the Unified Health System are consolidated should be taken into consideration, in compliance with the details in Article 7 of Law No. 8,080/90, noting, for example, if:

- The potential of health services and the possibilities of utilization by the users are being properly disseminated to the population;
- Setting priorities, allocating resources and programmatic guidance are based on epidemiology
- Plans, programs, projects and activities that implement the National Food and Nutrition Policy are operated in decentralized manner, considering the command and responsibilities at each level of management.

The process of monitoring and evaluation of this policy will also involve the assessment of compliance with related international

commitments signed by Brazil. Among these commitments, those lead by the United Nations, represented by various international agencies such as FAO, WHO, UNICEF and the UN High Commissioner for Human Rights, which are intended to incorporate food and nutrition concepts, objectives, goals and strategies to the agenda of governments, must be highlighted.

4.5 Social Participation and Control

The Unified Health System is a landmark of democratic and participatory making of public policies in Brazil. Its legislation has defined mechanisms so that public participation is key to its constitution and takes part in its operation through the practice of social control in the Health Councils and Conferences in all the three government levels.

The formulation of health plans should emerge from the spaces where the construction of decentralized management, the development of comprehensive health care and the strengthening of public participation, with deliberative power and/or an advisory character, are placed close together.

The intersectoral perspectives of Health and Food and Nutrition Security allow the citizens to be considered in their entirety, in their individual and collective needs, demonstrating that resolutive initiatives in these areas necessarily require partnerships with other sectors such as Education, Labor, Housing, Culture and others. Thus, the context of intersectoriality encourages and requires mechanisms that involve society. This demands the participation of social movements in available decision-making processes related to their quality of life and health.

Thus, the debate about PNAN and its initiatives in various consultative and deliberative forums, conferences, seminars and others, creates conditions for reaffirming its social and political project and should be encouraged, so that the Health Councils and Conferences represent privileged spaces for discussion of food and nutrition actions in the Unified Health System.

The Intersectoral Committee for Food and Nutrition is one of the committees of the National Health Council (CNS) created by Law No. 8.080/90 and its purpose is to monitor, propose and assess the implementation of the guidelines and priorities of the PNAN and promote cooperation and complementarity of policies, programs and activities of interest to health, whose execution involves areas not included in the specific context of the Unified Health System (BRAZIL, 1990). The creation of Intersectoral Food and Nutrition Committees (CIAN) in states, districts and cities will empower the debate about the PNAN in the agenda of their Health Councils. Therefore, the role of health councilors in expressing social demands relative to the human rights to health and nutrition and defining and monitoring of initiatives originating from the PNAN in its scope of action should be strengthened accordingly.

The institution of the National Food and Nutrition Security Council - CONSEA, the National Conferences on Food and Nutrition Security and the simultaneous strengthening of the various forums and councils on policies related to food and nutrition security offer, as a challenge to the CNS and CIAN, broadening the dialogue and seeking consensus to democratically build the demands of civil society about the PNAN and on the set of related programs and policies.

Social participation must be present in the daily processes of the Unified Health System, and cross-cut its set of principles and guidelines. Thus, the active role of the population in the fighting for their rights to health and nutrition through the creation and strengthening of spaces for listening to society, for public participation in solving demands and promoting social inclusion of specific populations should be recognized and supported.

4.6 Qualification of the Workforce

The food and nutrition situation of the Brazilian population and the National Health Plan, combined with the movement in defense of food and nutrition security, provide important information for ordering the training of health sector workers involved in the food and nutrition agenda in the Unified Health System. In this context, it is essential to align the qualification of professionals with the population's health, diet and nutrition needs, and it is strategic to consider the working process in health as a basis to organize the training of the workforce.

It is necessary to develop and strengthen technical mechanisms and organizational strategies for qualifying the workforce for management and nutritional care, to value health professionals by stimulating and enabling professional formation and permanent education, guaranteeing worker's rights and social security, qualifying job contracts and establishing careers that associate the development of workers with the qualification of services offered to users.

The qualification of managers and all health workers to implement food and nutrition policies, programs and initiatives aimed at food and nutrition care and surveillance, promotion of adequate and healthy eating and food and nutrition security, represents an historical and strategic need to confront the diseases and health problems arising from the current Brazilian food and nutrition scenario.

Permanent health education is shown to be the main strategy for qualifying care, management and public participation practices. It should be based on a pedagogical process based on the everyday work, involving practices that can be defined by multiple factors (knowledge, values, power relations, planning and work organization) and which include elements that make sense to the actors involved. The changes in management and care are more effective when produced by affirming the autonomy of the individuals involved, who share responsibilities among themselves in the management and care processes.

It would be particularly important to establish joint cooperation strategies for managers with educational institutions to develop on-site training projects, fields for extension courses and research in the Health Care Network of the Unified Health System that enable the development of care practices related to food and nutrition.

Undergraduate and postgraduate courses in the health field, especially nutrition, should include the training professionals who will meet the social needs in food and nutrition that are in line with the principles of the Unified Health System and the PNAN.

The Collaborating Centers for Food and Nutrition (CECANs), located in public education and research institutions and accredited by the Ministry of Health to support the development of strategies that enhance the initiatives of PNAN, are strategic partners to articulate the needs of the Unified Health System with the formation and qualification of health professionals for the food and nutrition agenda.

4.7 Food Control and Regulation

The planning of initiatives to ensure the innocuity and nutritional quality of foods, controlling and preventing risks to health is part of the agendas of promotion of adequate and healthy eating and of health protection. The concern in offering healthy food and guaranteeing of biological, sanitary, nutritional and technological quality to people, is the end product of a chain of processes from production (including traditional and family agriculture), processing, manufacturing, commerce and supply, up to distribution, whose responsibility is shared with different sectors of the government and society.

The current complexity of the food production chain places Brazilian society in the path of new health risks, such as the presence of pesticides, additives, contaminants and genetically modified organisms and an inadequate nutritional profile of the foods. The advances in technology contribute to a greater supply and variety of foods on the market and a high degree of food processing, which composition is affected by the excessive use of sugar, sodium and fats, creating high energy density foods. These new formulations, combined with the increased consumption of meals outside the home, require adjustments in food regulation.

In this context, sanitary safety pursues protecting human health, taking into account the changes occurring in the production chain up to the consumption of foods, in the social and cultural patterns arising from globalization and in the adaptations to food production methods on an international scale. Thus, sanitary risks must focus on an integrated approach to health and consider, besides themselves, the nutritional risks arising from this scenario, increasing the capacity of the State to use the necessary legal instruments of control to protect the health of the population.

The PNAN and the National Health Surveillance System - SNVS converge in order to promote and protect the health of the population in the perspective of the human right to food, through regulations and sanitary control of food production, commerce and distribution.

The sanitary measures adopted for foods are based on risk analysis, considering risk as the probability of an adverse health effect resulting from a physical, chemical or biological threat with the potential to cause adverse health effects. Thus, it is important to use the risk analysis tool to monitor and ensure the provision of nutritionally adequate and safe food to the population, while respecting the individual right to choose and decide on the risks to which they are willing to be exposed. Along these lines, implementing and using Good Agricultural Practices, Good Manufacturing Practices, Good Nutritional Practices and the Hazard Analysis and Critical Control Point System - HACCP in the food production chain, enhances and ensures initiatives to protect consumer health.

So that food sanitary control departments may enable initiatives of monitoring and responding appropriately to the demands presented to them, they need to be fitted with rapid response capability, with an agile system that allows monitoring these actions in order to reevaluate processes and produce information to support decision making. Thus, it is necessary to revise and improve sanitary regulations and orient them in conformity with the national guidelines for the Promotion of Adequate and Healthy Eating and the guarantee of the human right to food, and to strengthen the technical and analytical capacity of national health surveillance network.

The monitoring of food quality should take sanitary aspects, such as microbiological and toxicological, into account, as well as food nutritional profile, such as levels of macro and micronutrients, articulated with strategies for mandatory fortification of foods and with the reformulation of the nutritional profile of processed foods in order to reduce fats, sugars and sodium.

Specifically, the action of monitoring food advertising and publicity should pursue improving the right to information in a clear and concise manner, in order to protect consumers from potentially abusive and deceptive practices and to promote individual autonomy for healthy food choices. This strategy should limit the publicity of unhealthy foods to children and improve the regulation of food advertising by monitoring and enforcing regulations governing food publicity.

Communication and the channels of interaction with consumers must be expanded, establishing continuous information initiatives so that measures for control and regulation are understood and fully

used by the population. A greater understanding of the perception of nutritional and health risks by consumers is key to the development of effective strategies to cope with inappropriate eating practices.

Nutritional labeling of foods is a central tool for improving the right to information. Access to information strengthens the capacity of analysis and decision on the part of the consumer, so this tool must be clear and precise so that it can assist in choosing healthier foods. Despite legislative progress in mandatory nutrition labeling, it is still possible to encounter overly technical information and advertising that can lead to misinterpretation. Thus it is necessary to improve the mandatory information on food labels to make it more understandable and extend the use of these rules to other sectors of food production.

The actions related to the regulation of food must be coordinated and integrated to ensure the innocuity and nutritional quality of foods, with the institutional strengthening of sectors committed to public health and the transparency of the regulatory process - particularly of pesticides in food, food additives and foods intended for population groups with specific dietary needs.

Brazil is currently a member of the Southern Common Market - Mercosul, which has regulatory policies that establish fair trade practices for food products by the internalization and harmonization of international laws. These standards are widely discussed in order to establish the free circulation of safe and healthy foods, adapted to the public policies and programs of each country. The Codex Alimentarius is another international forum for the food regulation, in which Brazil takes part and must take into account its recommendations in order to protect the health and nutrition of the Brazilian population.

4.8 Research, Innovation and Knowledge in Food and Nutrition

The development of knowledge and the support to research, innovation and technology in the field of food and nutrition in public health enable generating the evidence and tools necessary for the implementation of the PNAN.

With regard to knowledge of the food and nutritional situation, Brazil currently has health information systems and in particular, SISVAN, as well as periodic national and local populational surveys. In this respect, it is important that these sources of information are maintained and strengthened and that documentation of the food and that the nutritional diagnosis of the Brazilian population is carried out by regions, states, population groups, ethnic groups, race/color, gender and education, among other profiles that allow visualizing the social determination of the phenomenon.

It is essential to maintain and encourage investments in research for outlining and evaluating new interventions and evaluating programs and initiatives proposed by PNAN, so that managers are provided with a solid base of evidence to support planning and decision-making for nutritional care in the Unified Health System. Therefore, the priority schedule for research in food and nutrition of national and regional interest must be kept updated, based on the national agenda of priorities for health research.

Thus, it is important to increase the technical, scientific and financial support to the lines of research allied to the demands of the health services, which develop methodologies and tools applied to management, implementation, monitoring and evaluation of initiatives

related to the PNAN. To this end, the Collaborating Centers for Food and Nutrition (CECANs) constitute a collaborative interinstitutional network of technical and scientific cooperation, which should be improved and strengthened once they produce evidence that contributes to the strengthening of management and nutritional care in the Health Care Network of the Unified Health System.

4.9 Cooperation and coordination for Food and Nutritional Security

Food and Nutritional Security (SAN) is the realization of all people's right of to regular and permanent access to quality food in sufficient quantity, without compromising access to other essential needs, based on food practices that promote health, that respect cultural diversity and that are environmentally, culturally, economically and socially sustainable. This concept encompasses issues related to food production and availability (sufficiency, stability, autonomy and sustainability) and the concern for health promotion, linking the two approaches that guided the construction of the SAN concept in Brazil: the socioeconomic approach and health and nutrition approach.

Ensuring food and nutrition security for the population as well as guaranteeing the right to health does not depend exclusively on the health sector, although this sector plays an essential role in the process of intersectoral coordination.

The intersectoral approach allows establishing shared spaces of decision-making among different institutions and sectors of the government that operate in the production of health and food and nutrition security by formulating, implementing and monitoring public

policies that can have a positive impact the population's health. Thus, the National Food and Nutrition Policy (PNAN) must interact with the National Food and Nutrition Security Policy (PNSAN) and with other economic and social development policies, playing an important role in the strategy of developing SAN policies, mainly in aspects related to the diagnosis and surveillance of the food and nutrition situation and the promotion of adequate and healthy eating.

The coordination and cooperation between the Unified Health System (SUS) and the National Food Security and Nutrition System (SISAN) will provide the strengthening of food and nutrition initiatives in the Health Care Network, linked to the other SAN initiatives for addressing food and nutritional insecurity and health problems from the perspective of their social determinants.

Special attention must be given to actions directed to: (i) improving the health and nutrition of families that belong to income transfer programs, which imply increasing the access to health services, (ii) dialoguing with the sectors responsible for agricultural production, distribution, supply and local food trade in order to increase access to healthy foods, (iii) promoting adequate and healthy eating in institutional settings such as schools, daycare centers, prisons, shelters, workplaces, hospitals and community restaurants, among others, (iv) linking with educational and social assistance networks to promote food and nutrition education, (v) articulating with sanitary surveillance to regulate the quality of processed foods and to support food production from family agriculture, agrarian reform settlements and traditional communities, integrated to the dynamics of food production in the country.

5 INSTITUTIONAL RESPONSIBILITIES

In observance of the principles of the Unified Health System, health managers at all three government levels, in an cooperative manner and in compliance with their general and specific duties, will act to enable the achievement of the purpose of the National Food and Nutrition Policy.

5.1 Responsibilities of the Ministry of Health

- To develop an action plan within the planning and management tools to implement the PNAN, taking into account priority issues and regional specificities in a continuous fashion and coordinated with the National Health Plan and with the e planning and agreement tool of the Unified Health System;
- To agree, in the Intermanagerial Tripartite Commission, priorities, on objectives, strategies and goals for the implementation of food and nutrition programs and initiatives in the Health Care Network, maintaining the principles and general guidelines of the PNAN;
- To ensure sources of federal funds to take part in the financing of food and nutrition programs and initiatives in the State, Federal District and Municipal Health Care Networks;
- To assess and monitor the national food and nutrition goals for the health sector, according to the epidemiological and nutritional situation and regional specificities;
- To provide technical advisory and institutional support in the processes of management, planning, implementation,

monitoring and evaluation of the food and nutrition programs and initiatives in the Health Care Network;

- To support the coordination of institutions, in partnership with the State, Municipal and Federal District Health Departments for the training and continuous education of health professionals for management, planning, implementation, monitoring and evaluation of food and nutrition programs and initiatives in the Unified Health System;
- To provide technical assistance to states, the Federal District and municipalities in the implementation of information systems for food and nutrition programs and other health information systems that contain food and nutrition indicators;
- To support the organization of a network of Collaborating Centers for Food and Nutrition, promoting knowledge and building evidences in the field food and nutrition for the Unified Health System
- To support and promote the execution of strategic surveys in the context of this policy, keeping an updated agenda of survey priorities in Food and Nutrition for the Unified Health System;
- To promote, within the scope of its competence, the intersectoral and interinstitutional coordination required for implementing the PNAN guidelines and the coordination of the Unified Health System with SISAN;
- To encourage and support the process of discussion about initiatives and programs in food and nutrition in the Health Care Network, with participation of the organized sectors of society in the collegiate and social control spaces, especially in Intersectoral Committee for Food and Nutrition (CIAN) of

the National Health Council and in the National Food and Nutrition Security Council;

- To facilitate and establish partnerships with international bodies, governmental and nongovernmental organizations and the private sector, guided by the needs of the population and by public interest, assessing risks to the common good, with autonomy and respect for ethical principles, to guarantee the rights to health and nutrition and the food and nutritional safety of the Brazilian people.

5.2 Responsibilities of the State and Federal District Health Departments

- To implement the PNAN within its territory, respecting its guidelines and promoting the necessary adaptations, according to the epidemiological profile and regional and local specificities;
- To agree, in the Bipartite Intermanagerial Commission and the Intermanagerial Regional Committees, on priorities, objectives, strategies and targets for implementing food and nutrition programs and initiatives in the Health Care Network, according to the principles and general guidelines of the PNAN;
- To develop an action plan for implementing the PNAN, taking into account priority issues and regional specificities in a continuous and coordinated fashion with the State Health Plan and the Unified Health System planning and agreement tools;
- To allocate state funds to take part in the tripartite funding

of the food and nutrition initiatives in the Health Care Network at the state level;

- To provide technical advice and institutional support to municipalities and regional health departments in the processes of managing, planning, executing, monitoring and evaluating food and nutrition programs and initiatives.
- To develop technical and organizational strategies for training and continuous education of health workers for managing, planning, executing, monitoring and evaluating food and nutrition programs and initiatives at the state level, respecting local diversity and in accordance with the PNAN;
- To promote, within the sphere of its competence, the intersectoral and interinstitutional coordination required for implementing the PNAN guidelines and coordination of the Unified Health System (SUS) with the National Food and Nutrition Security System (SISAN) at the state level;
- To facilitate and establish partnerships with international bodies, governmental and nongovernmental organizations and the private sector, guided by the needs of the population of the region and by public interest, assessing risks to the common good, with autonomy and respect for ethical principles, to guarantee the rights to health and nutrition and the food and nutritional safety.

5.3 Responsibilities of the Municipal and Federal District Health Departments

- To implement the PNAN within its territory, respecting its guidelines and encouraging the necessary adaptations, according to the epidemiological profile and the specific local

conditions, considering the criteria of risk and vulnerability;

- To develop an action plan for the implementation of the PNAN in municipalities, defining priorities, objectives, strategies and goals in a continuous and coordinated fashion with the Municipal Health Plan and integrated regional planning, if any, and the Unified Health System planning and agreement tools;
- To allocate municipal resources to take part in the tripartite funding of food and nutrition initiatives in the Health Care Network;
- To continuously agree on, monitor and evaluate food and nutrition indicators and provide input to health information systems, with data produced by the local health system;
- To develop technical and organizational strategies for the training and continuous education of health workers for managing, planning, implementing, monitoring and evaluating food and nutrition programs and initiatives in the municipal arena and/or regional health departments;
- To strengthen social participation and control in planning, implementation, monitoring and evaluation of food and nutrition programs and initiatives within the Municipal Health Council and other social control spaces in the municipality;
- To encourage, within the sphere of its competence, the intersectoral and interinstitutional coordination required for implementing the PNAN guidelines and coordination of the Unified Health System (SUS) with the National Food and Nutrition Security System (SISAN) at the municipal level;
- To facilitate and establish partnerships with international agencies, governmental and nongovernmental organizations and the private sector, guided by the needs of the population of municipalities and the Federal District, and by public interest,

assessing the risks for the common good, with autonomy and respect for ethical precepts, to guarantee the rights to health and nutrition and the food and nutrition security.

6 REFERENCES

AGÊNCIA NACIONAL DE VIGILÂNCIA SANITÁRIA (ANVISA). **Resolução RCD nº 63, de 6 de julho de 2000.** Aprova o Regulamento Técnico para fixar os requisitos mínimos exigidos para a Terapia de Nutrição Enteral. Brasil, jul. 2000.

APPOLINARIO, J. C.; CLAUDINO, A. M. Transtornos alimentares. **Rev. Bras. Psiquiatria. [online].** v. 22, suppl. 2, 2000, p. 28-31. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1516-44462000000600008&lng=en&nrm=iso>. Acesso em: fev. 2011.

BRASIL. Comissão Nacional sobre Determinantes Sociais da Saúde (CNDSS). **As causas sociais das iniquidades em saúde no Brasil:** relatório final. Brasília: Fiocruz, 2008a.

BRASIL. Conselho Federal de Nutrição (CFN). Resolução nº 380, de 2005. Dispõe sobre a definição das áreas de atuação do nutricionista e suas atribuições, estabelece parâmetros numéricos de referência, por área de atuação, e dá outras providências. **Diário Oficial [da] República Federativa do Brasil,** Seção 1, 10 jan. 2006a.

BRASIL. Conselho Nacional de Saúde. Resolução nº 011, de 31 de outubro de 1991. Institui as Comissões Intersetoriais Nacionais, integrantes do Conselho Nacional de Saúde. **Diário Oficial [da] República Federativa do Brasil,** Seção 1, 1 nov. 1991.

BRASIL. Conselho Nacional de Saúde. Resolução nº 373, de 14 de junho de 2007. Aprova a reestruturação da Comissão Intersetorial de Alimentação – CIAN. **Diário Oficial [da] República Federativa do Brasil**, Seção 1, 15 jun. 2007.

BRASIL. Conselho Nacional de Segurança Alimentar e Nutricional. Tradução Livre da Declaração de Nyélény. Foro Mundial pela Soberania Alimentar, Nyélény, Selingue, Mali, 28 de fevereiro de 2007. In: CONSEA. **Manual orientador da 4ª Conferência Nacional de Segurança Alimentar e Nutricional.** Brasília, 2011a.

BRASIL. Constituição (1988). **Emenda Constitucional nº 64, de 4 de fevereiro de 2010.** Altera o art. 6º da Constituição Federal, para introduzir a alimentação como direito social. Brasil, 2010a.

BRASIL. **Decreto nº 7.272, de 25 de agosto de 2010.** Regulamenta a Lei nº 11.346, de 15 de setembro de 2006, que cria o Sistema Nacional de Segurança Alimentar e Nutricional - SISAN com vistas a assegurar o direito humano à alimentação adequada, institui a Política Nacional de Segurança Alimentar e Nutricional - PNSAN, estabelece os parâmetros para a elaboração do Plano Nacional de Segurança Alimentar e Nutricional, e dá outras providências. Brasil, 26 ago. 2010b.

BRASIL. **Decreto nº 7.508, de 28 de junho de 2011.** Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde - SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. Brasil, 29 jun. 2011a.

BRASIL. Lei nº 8080, de 19 de setembro de 1990. Dispõe sobre as condições para promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. **Diário Oficial [da] República Federativa do Brasil**, Seção 1, 20 set. 1990, p. 18055.

BRASIL. Lei nº 11.346, de 15 de setembro de 2006. Cria o Sistema Nacional de Segurança Alimentar e Nutricional – SISAN com vistas em assegurar o direito humano à alimentação adequada e dá outras providências. **Diário Oficial [da] República Federativa do Brasil**, Seção 1, 18 set. 2006b.

BRASIL. Lei Orgânica de Segurança Alimentar e Nutricional – LOSAN. Cria o Sistema Nacional de Segurança Alimentar e Nutricional – SISAN com vistas em assegurar o direito humano à alimentação adequada e dá outras providências. **Diário Oficial [da] República Federativa do Brasil**, 18 set. 2006c.

BRASIL. Ministério da Saúde, Centro Brasileiro de Análise e Planejamento. **Pesquisa Nacional de Demografia e Saúde da Criança e da Mulher:** PNDS 2006: dimensões do processo reprodutivo e da saúde da criança. Brasília: Ministério da Saúde, 2009a.

BRASIL. Ministério da Saúde. **Chamada Nutricional da Região Norte – 2007:** resumo executivo. Brasília: Ministério da Saúde, 2009b.

BRASIL. Ministério da Saúde. **Política Nacional de Humanização.** Brasília, 2004.

BRASIL. Ministério da Saúde. Portaria MS/GM nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, para a Estratégia de Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). **Diário Oficial [da] República Federativa do Brasil**, Seção 1, 22 out. 2011c.

BRASIL. Ministério da Saúde. Portaria nº 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). **Diário Oficial [da] República Federativa do Brasil**, Seção 1, p. 89, 31 dez. 2010c.

BRASIL. Ministério da Saúde. Secretaria de Vigilância em Saúde. Portaria nº 272/MS/SNVS, de 8 de abril de 1998. Aprova o Regulamento Técnico para fixar os requisitos mínimos exigidos para a Terapia de Nutrição Parenteral. **Diário Oficial [da] República Federativa do Brasil**, Seção 1, 23 abr. 1998.

BRASIL. Ministério da Saúde. **II Pesquisa de prevalência de aleitamento materno nas capitais brasileiras e Distrito Federal.** Brasília: Editora do Ministério da Saúde, 2009c.

BRASIL. Ministério do Desenvolvimento Social. **Políticas Sociais e Chamada Nutricional:** Quilombola: estudos sobre condições de vida nas comunidades e situação nutricional das crianças. Cadernos de Estudos: desenvolvimento social em debate. Brasília: Ministério do Desenvolvimento Social, n. 9, 2008b.

INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA (IBGE). **Pesquisa de Orçamentos Familiares POF 2002-2003.** Análise da

Disponibilidade Domiciliar de Alimentos e do Estado Nutricional no Brasil. Rio de Janeiro: IBGE, 2004.

INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA (IBGE). **Pesquisa de Orçamentos Familiares POF 2002-2003.** Antropometria e análise do estado nutricional de crianças e adolescentes no Brasil. Rio de Janeiro: IBGE, 2006.

INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA (IBGE). **Pesquisa de Orçamentos Familiares POF 2008-2009.** Antropometria e análise do estado nutricional de crianças, adolescentes e adultos no Brasil. Rio de Janeiro: IBGE, 2010.

MONTEIRO, Carlos Augusto et al. Causas do declínio da desnutrição infantil no Brasil, 1996-2007. **Revista de Saúde Pública**, São Paulo, v. 43, n. 1, p. 35-43.

PEREIRA, M. P. B; BARCELLOS, C. O Território no Programa Saúde da Família. **Hygeia - Rev. Bras. de Geografia Médica e da Saúde**, [s.l.], v. 2, n. 2, p. 47-55, jun. 2006.

WORLD HEALTH ASSEMBLY. **Estratégia global para a alimentação do bebê e da criança pequena.** Resolution WHA A55.15, Geneva, 16 abr. 2002.

WORLD HEALTH ORGANIZATION (WHO). **Estratégia global em alimentação saudável, atividade física e saúde.** 57ª Assembléia Mundial de Saúde, 25 maio 2004.

GLOSSARY

Adequate and healthy nutrition: a nutritional practice appropriate to the biological and sociocultural aspects of individuals as well as to sustainable use of the environment. It should comply with the requirements of each phase of life and with special dietary needs; be referenced by food culture and gender, race and ethnic profiles; be accessible from the physical and financial standpoint; be harmonious in quantity and quality; be based on adequate and sustainable production practices; with minimal amounts of physical, chemical and biological contaminants.

Primary health care: a series of health initiatives, both individual and collective, which include the health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, damage reduction and health maintenance in order to develop a comprehensive care that impacts on the health condition and autonomy of persons and the determinants and conditioning factors for health in communities. It is developed through the exercise of democratic and participatory care and management practices through teamwork, targeting populations in defined territories, and taking into account the dynamics of the territory where these populations live. It uses complex, varied care technologies are should assist in handling health requirements and needs of higher frequency and relevance in their territory, observing risk, vulnerability and resilience criteria and the ethical imperative that all demands, health needs and suffering should be accommodated.

Care Coordination: Acts as the center of communication among the various points of health care and is responsible for the care of

users at any of these points by means of a horizontal, continuous and integrated relationship in order to produce shared management for comprehensive care. Coordinating other needed public, community and social facilities as well for comprehensive health care.

Care related to food and nutrition: includes diagnosis and food and nutrition surveillance, promotion of adequate and healthy nutrition, food and nutritional education, nutritional guidance, dietary prescriptions, supply of food for special purposes, food provision in hospitals and enteral and parenteral nutritional support.

Clinical practice guidelines: recommendations that guide preventive and promotional care decisions such as organizing services for health issues related to sanitation, developed from the expanded understanding of the health-disease process, focusing on wholeness and incorporating the best testimonies from clinics, public health, health management and the creation of autonomy. The guidelines are broken down into Clinical Practice Guidelines/Care Protocols, orienting lines of care and enabling communication between teams and services, planning of initiatives and standardization of certain features.

Codex Alimentarius: a commission whose purpose is to discuss and develop food standards, regulations and other texts related to the protection of consumer health, ensuring transparent trade practices and promoting the coordination of food standards set by governmental and nongovernmental organizations.

Comprehensive health care: a series of initiatives for the promotion and protection of health, disease prevention, diagnosis, treatment,

rehabilitation, damage reduction and health maintenance, driven by the needs of the population, which include the professional's attitude in the meeting with users, the organization of health services and the construction of public policies to address the social determinants of health.

Dietetic Prescription: the private activity of a nutritionist, involving dietary planning based on guidelines established in the nutritional diagnosis, which makes up the care given to users of in-hospital, outpatient or home health care. This procedure should be accompanied by the signature and Regional Nutritionists Council (CRN) registration number of the nutritionist responsible for the prescription.

Eating disorders: deviations of eating behavior that can lead to extreme weight loss (cachexia) or obesity, among other physical problems and disabilities. They include: Anorexia nervosa, Bulimia nervosa, Orthorexia, Vigorexia, and Obsessive Compulsive Food Disorder, among others.

Enteral Nutrition: Food for special purposes, with controlled intake of nutrients in isolation or combination, with a defined or estimated composition, specially formulated and prepared for use with catheters or orally, industrialized or not, used exclusively or partially to replace or supplement oral feeding in malnourished patients or not, according to their nutritional needs, in the hospital, as outpatients or at home, for the purpose of synthesizing or maintaining tissues, organs or systems.

Food and Nutrition Security System (SISAN): a public system that enables nationwide intersectoral and participatory management and coordination among participants of the federation to implement public

policies that promote food and nutritional security from a perspective that complements each sector. It is composed of a number of agencies and entities of the Union, the States, the Federal District and Municipalities.

Food and nutritional security: according to Law No. 11,346 of September 15, 2006, this consists of the realization of the rights of everyone to regular and ongoing access to quality food in sufficient quantity, without compromising access to other essential needs, based on health promoting eating practices that respect cultural diversity and that are environmentally, culturally, economically and socially sustainable.

Food and nutritional surveillance: is the continuous description and prediction of trends in food and nutritional conditions of the population and its determining factors. It should be considered from an approach that incorporates expanded surveillance in healthcare and integration of information derived from information systems in health, population surveys, sampling for diagnosis of nutitional status and scientific production.

Foods for special purposes: foods specially formulated or processed, in which changes are made in nutrient content suitable for use in different or optional diets and that meet the needs of people with specific physiological and metabolic conditions.

Food Sovereignty: in accordance with the Declaration of Nyélény (2007), "it is a right of peoples to have nutritious and culturally adequate food, accessible, produced sustainably and ecologically, and their right to decide their own food and production system. This puts those who produce, distribute and consume food at the heart of food systems

and policies, above the demands of markets and businesses. (...) Food sovereignty promotes transparent trade that guarantees a decent income for all peoples, and the rights of consumers to control their own food and nutrition. It guarantees that the rights of access to and management of land, territories, water, seeds, livestock and biodiversity are in the hands of those who produce food. Food sovereignty implies new social relations free from oppression and inequality among men and women, racial groups, social classes and generations."

Health Care Network: defined as organizational arrangements for health services and initiatives of different technology densities which, integrated through systems of technical, logistical and management support, seek to ensure comprehensive care. Their goal is to promote the systemic integration of health initiatives and services with the provision of ongoing, comprehensive, quality, responsible and humanized care, as well as increase the system's performance in terms of access, equity, clinical and sanitary effectiveness, and economic efficiency. The network is characterized by the formation of horizontal relations between points of care with the communication center in Primary Care, through the centrality of health needs of a population, accountability for ongoing and comprehensive care, through multiprofessional care, through sharing goals and commitments with sanitary and economic results. It is based on the understanding of PC as the first level of care, emphasizing the resolutive function of Primary Care in resolving the most common health problems and from which it conducts and coordinates care across all points of care.

Health Care Points: seen as spaces that offer certain health services, through a unique method. Examples: households, basic health units, specialized outpatient units, hemotherapy and hematology services,

psychosocial support centers and therapeutic residences, among others. Hospitals may house different points of health care: outpatient emergency care, outpatient surgery unit, surgery center, maternity, intensive therapy unit and mental health unit (day unit), among others. All points of health care are equally important in order to meet the objectives of the health care network and differ only by the distinct technological densities that characterize them.

Humanization: the valuation of different subjects pertaining to the process of health production (users, workers and managers); support for autonomy and the role of these subjects, increasing the degree of co-responsibility in the production of health and of subjects, establishing links of solidarity and collective participation in the management process; identification of health needs; changes in the models of care and management of work processes focusing on the needs of citizens and the production of health; commitment to the environment, improvement of working and service conditions.

Human right to adequate food: the human right belonging to all people to have regular ongoing and unrestricted access, either directly or by means of financial purchases, to safe and wholesome food in adequate and sufficient quantity and quality, corresponding to the cultural traditions of the people and which ensure a life free of fear, worthy and full in the physical and mental, individual and collective sense.

Inborn errors of metabolism: a series of genetically determined diseases caused by deficiency in some metabolic pathway that is involved in the synthesis (anabolism), transport or degradation (catabolism) of a substance.

The "Guthrie Test," a compulsory test of the Newborn Screening Program detects diseases of higher incidence such as phenylketonuria, congenital hypothyroidism, sickle cell anemia, cystic fibrosis and hemoglobinopathies.

Intersectorality: links between different sectors to address complex problems in order to overcome the fragmentation of policies in the various areas where they are executed.

Lines of care: a way of coordinating resources and practices for the production of health, oriented by clinical guidelines among the care units of a given health region, to lead users in a timely, speedy and unique manner to possibilities for diagnosis and therapy, in response to the most relevant epidemiological needs. They seek coordination throughout the care period, through agreement/contracting and the connectivity of roles and tasks of different professional points of care. They assume a global response from the professionals involved in care and subjugate fragmented responses. Implementation of Lines of Care (LC) must start from the Primary Care Units, which have responsibility for coordinating the care and management of the network. Several assumptions must be observed for the effectiveness of the LC, as a guarantee of material and human resources necessary for its operation; integration and co-responsibility of health facilities; interaction between teams; ongoing education processes; management agreed upon commitments and results. These points should be the responsibility of the technical group, with monitoring by regional management.

Matrix-based Support Team: a group of professionals who do not necessarily have a direct daily relationship with the user, but whose job is to provide support to the reference teams to ensure, in a dynamic and

interactive manner, specialized support to the reference teams in care giving (direct actions with users) and the technical-pedagogical aspects (educational support initiatives with and for the team). To this end, there should be an understanding of what the matrix-based professionals' core knowledge is and what is common knowledge and capable of being shared with the reference teams.

National System of Sanitary Surveillance (SNVS): comprises a set of actions defined in Law No. 8,080/1990, executed by direct and indirect public administration institutions of the Unions, the States, the Federal District and Municipalities engaged in activities of regulation, standardization, control and inspection in the area of sanitary surveillance.

Nutritional assessment: analysis of direct (clinical, biochemical, anthropometric) and indirect (food consumption, income and food availability, etc.) indicators whose conclusion is the nutritional diagnosis of the individual or a population.

Nutritional care: Includes care relating to food and nutrition focused on the promotion and protection of health, prevention, diagnosis and treatment of diseases, which should be linked to other SHS health care initiatives for individuals, families and communities, contributing to the creation of an integrated, resolutive, humanized care network.

Nutritional diagnosis: identification and determination of nutritional status, based on clinical, biochemical, anthropometric and dietary data obtained from the nutritional assessment of individuals or collectives.

Nutritional supplements: food that complements, with calories and nutrients, the daily diet of a healthy person in cases where their intake from food is insufficient, or when the diet requires supplementation.

Nutritional therapy: a series of therapeutic procedures for maintenance or recovery of the patient's nutritional status by means of Parenteral and Enteral Nutrition.

Parenteral Nutrition: a solution or emulsion, composed primarily of carbohydrates, amino acids, lipids, vitamins and minerals, sterile and pyrogen-free, packaged in glass or plastic and intended for intravenous administration in malnourished patients or not, in the hospital, as outpatients or at home, for the purpose of synthesizing or maintaining tissues, organs or systems.

Reception: the practice of receiving, listening, welcoming, accepting, listening, giving people credit, an attitude of inclusion, which should be present in all care relationships, in actual encounters between workers and users of health services.

Reference team: the team of Primary Care professionals responsible for the enrolled population of a given territory. The proposal of the Primary Care reference team assumes that there is interdependence among professionals. They prioritize the building of common goals in a team with a well-defined enrolled clientele. Thus, one of the important functions of the coordination (management) of a reference team is precisely to produce a positive interaction among professionals in pursuit of common goals, despite their differences, without trying to eliminate these differences, but taking advantage of the richness they provide.

Southern Common Market - Mercosur: an area of free movement of goods with a standard commercial tax rate for a group of countries. There is a common trade policy of countries in South America, at the moment composed of four countries: Argentina, Brazil, Paraguay and Uruguay.

Territorialization: a process of demarcation of the areas of health services, recognition of the environment, population and social dynamics within such areas, and identification and establishment of horizontal relations with other social services and facilities in the territory.

Traditional Peoples and Communities: according to Decree No. 6,040 of February 7, 2007 that establishes the National Policy for Sustainable Development of Traditional Peoples and Communities, these are culturally diverse groups that recognize themselves as such, who have their own forms of social organization, who occupy and use lands and natural resources as a condition for their cultural, social, religious, ancestral and economic production, using knowledge, innovations and practices generated and transmitted through tradition. They include Indigenous People, Quilombolas, Faxinalenses, Geraizeiros, Marsh Communities, Caiçaras, Riparian Communities, Rubber Tappers, Brazil Nut Gatherers, Babassu Breakers, Gypsies, Candomble Communities, Pomeranians, Caatingueiros, Agroextractivist, Tidewater Settlers and Artisanal Fishermen.

Vitamin and/or mineral supplements: foods that complement, with other nutrients, the daily diet of a healthy person, in cases where their intake from food is insufficient, or when the diet requires supplementation. They must contain at least 25% and 100% of the recommended daily intake (RDI) of vitamins and/or minerals, in the daily portion specified by the manufacturer, cannot replace food, nor are they considered to be an exclusive diet.

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