Ministry of Health
Secretariat of Health Surveillance
Department for the Analysis of the Health Condition
General Coordination of Noncommunicable Diseases and Illnesses

Research Report:

Mapping of Surveillance, Prevention and Control Initiatives for Chronic Noncommunicable Diseases in Brazil, 1999–2005—

Subsidies to Formulate a National Policy on Integrated Surveillance

Axis:
National Policy on Food and Nutrition (PNAN), 1999–2005

Coordination Team of the Observatory for
Surveillance, Prevention and Control of Chronic Noncommunicable Diseases (OPDCNT)

- **Deborah de Carvalho Malta (SVS/MS)**
- **Denise Bomtempo Birche de Carvalho (University of Brasília)**
- **Otaliba Libânio de Moraes Neto (SVS/MS)**
- **Elisabeth Carmem Duarte (SVS/MS)**
- **Luciana Sardinha (SVS/MS)**
- **Lenildo de Moura (SVS/MS)**
- **Marília Mendonça Leão (CGPAN/MS)**
- **Anelise Rizzolo (CGPAN/MS)**

(Brasilia, June 2006)

Specialists linked to the Brazilian Committee of the Observatory for Surveillance, Prevention and Control of CNCDs (OPDCNT)

- Isabella Samico - Health Evaluation (CGIAE-SVS)
- Iná Santos - Epidemiologist (UFPEL)
-
- Sonia Natal - Health Evaluation (ENSP)
- Aloysio Achutti - Cardiologist / Tobacco policy (AMRIGS)
- Pedro Rodrigues Hallal - Phys Ed (UFPEL)
- Yara Carvalho - PhysEd /Dr. Colective He. (USP)
- Dilian Goullart - CGPAN -MS

Assistant Researchers

- Juliana Rochet , Andréa Fucks, Tânia Maria Tosta da Silva
-

International Cooperation - PAHO

- Lucimar Coser Cannon
- Branka Legetic
-
-

WHO Collaborating Center, Canada

- Clarence Clottey, Silvie Stachenco, Ellen Voggel

Revised by

- Tânia Maria Tosta da Silva

Acknowledgments

We thank the interviewees, for their contribution to the research process and the production of knowledge with a view to subsidize the formulation of an integrated policy on the prevention, control and surveillance of chronic noncommunicable diseases in Brazil.

Table of Contents

Abbreviations

ABIN	Brazilian Association of the Nutrition Industry
ASBRAN	Brazilian Nutrition Association
ABRANDH	Brazilian Association on Food and Nutrition and Human Rights ANVISA
	Brazilian Health Surveillance Agency
ATAN	Technical Area on Food
CFN	Federal Nutrition Council
CGDANT	General Coordination of Noncommunicable Diseases and Illnesses
CGPAN	General Coordination of Food and Nutrition Policies
CIAN	Intersectoral Commission on Food and Nutrition
CNA	National Food Commission
CNAE	National Commission on School Nutrition
CNAS	National Council for Social Assistance
CNRH	National Center on Human Resources
CNS	National Health Council
CNSAN	National Conference on Food and Nutritional Security
COBAL	Brazilian Food Company
CONASEMS	National Council of Municipal Health Secretaries
CONASS	National Council of Health Secretaries
CONEP	Commission on Ethics and Research
CONSEA	National Council on Food Security
CSA	Food Security Council
CSUs	Urban Social Centers
NCDs	Noncommunicable Diseases
CNCDs	Chronic Noncommunicable Diseases
CVD	Cardiovasculares Diseases
DHAA	Human Right to Food
ENDEF	National Study on Family Expenses
ENSP	National School on Public Health
FAO	United Nations Food and Agriculture Organization
FAE	Student Welfare Foundation
FIBGE	Brazilian Institute on Geography and Statistics Foundation

FIOCRUZ	Oswaldo Cruz Foundation
FSESP	National Foundation on Public Health Services
IBASE	Brazilian Institute for Social and Economic Analysis
IDEC	Brazilian Institute for Consumer Protection
IHAC	Children's Friend Hospital Initiative
INAE	National Institute for Assistance to the Student
INAN	National Institute on Food and Nutrition
INESP	Higher Education and Research Institute
IPEA	Institute of Economic and Applied Research
LOS	Organic Law on Health
MDA	Ministry of Agrarian Development
MCT	Ministry of Science and Technology
MDS	Ministry of Social Development and Hunger Combat
MAPA	Ministry for Agriculture, Livestock and Supply
WHO	World Health Organization
PAHO	Pan American Health Organization
OPDCNT	Observatory of Chronic noncommunicable Diseases Surveillance, Prevention and Control Policies
PAB	Minimum for Basic Service
PACS	Program for Health Communitary Agents
PAE	Economic Action Plan
PAN	Nutritional Support Program
PASEP	Program to Structure the Civil Servant Patrimony
PASS	Program on Social Action and Sanitation
PAT	Workers' Food Program
PBA	Food Allowance Program
PCA	Supplementary Nutrition Program
PCS	Solidary Community Program
PED	Development Strategic Plan
PGRM	Guaranteed Minimum Income Program
PIASS	Program for Interiorization of Health and Sanitation Services
PIE	Employment Mediation Program
PIS	Social Integration Plan
PLANFOR	National Program for Professional Education

PNAA	National Program for Access to Food
PNAE	National Program for School Nutrition
PNAN	National Policy on Food and Nutrition
PNBEM	National Policy for Child Welfare
PND	National Development Plan
PNI	Immunization Program
PNIAM	National Program to Promote Breast Feeding
PNLCC	National Program of the Milk for Poor Children
PNM	National Child Program
PNS	Nutrition in Health Program
PNSA	National Council on Food Security
PRODEA	Emergency Food Distribution Program
PRODECOR	National Program for Rural Communities Development
PROGER	Program for Creation of Employment and Remuneration
PRONAF	National Program to Strengthen Family Agriculture
PRONAN	National Program on Food and Nutrition
PSA	Food Security Policy
PSA	Supplementary Nutrition Program
PSMI	Mother-Infant Health Program
SAN	Food and Nutritional Security
SAPS	Social Security's Food Service
SBSA	Brazilian Soil for Food Security
SEAC	Community Action Secretariat
SINE	National Employment System
SISVAN	Food and Nutrition Surveillance System
SNME	National Service for School Lunch
SPS	Secretariat of Health Policies
SUS	Single Health System
SVS	Secretariat of Health Surveillance
TCLE	Free and Informed Consent Term
UFBA	Bahia Federal University
UFPE	Pernambuco Federal University
UNICEF	United Nations Children's Fund
USP	São Paulo University

1. Introduction

This research focuses on two fundamental and complementary aspects:

1. Mapping governmental initiatives to prevent and control chronic noncommunicable diseases (CNCDs) in Brazil, within fiive fundamental points of the public health issue, which are: The National Policy on Food and Nutrition (PNAN); the National Policy to Combat Smoking; Diabetes and Hypertension Watch; Physical Activity; Surveillance.

2. Analysing the formulation process for the public action initiatives aiming at protecting and promoting health. Such analysis will be built based on the reconstitution of policy fundamentals and criteria present in the decision taking process to formulate initiatives related to the prevention and control of CNCDs.

By analyzing CNCDs, in a broad meaning, considering the debate being held in the public health area (LESSA, 1998, 2004), one can notice the modifications of morbi-mortality patterns in the population, as from the 1960s. This event is characterized, among other indicators, by a gradual drop in the number of deaths by communicable infectious diseases and the gradual increase of deaths by noncommunicable diseases.

This process, identified as Epidemiologic Transition, represents the reflection in the public health, of a series of common changes that have occurred in the collective life dynamics, such as demographic, economic and social alterations, the increase in the exposure to unhealthy life habits such as smoking, sedentarism, and inadequate eating habits, among others.

According to Health Ministry data (2004) Chronic Noncommunicable Diseases—CNCDs—were responsible for the majority of deaths and hospital care expenses in the

Brazilian Single Health System (SUS), reaching approximately 69% of the expenses with health care in 2002. Since the 1960's, Cardiovascular Diseases (CVD) are leading the death numbers in Brazil, and presently, they are the main cause of death in about two thirds of the total of deaths with known causes (HEALTH MINISTRY, 2004).

In 2003, these diseases caused 274.068 (31.5%) of the deaths with determined causes (table 1), in the following proportion (table 2): cerebral vascular diseases (32.5%), ischemic diseases (30.4%), hypertensive diseases (10.2%), heart insufficiency (9.9%).

Table 1:
Deaths According to Group of Causes, Brazil, 2003

Causes of Death	***No. Deaths***	***%***
1- Cardiovascular Diseases	274,068	31.5%
2- Neoplasy (tumors)	134,691	15.5%
4- External Causes	126,657	14.6%
5- Respiratory Diseases	97,656	11.2%
6- Endocrine, Nutr. And Met. D.	51,190	5.9%
7- Digest System Diseases	46,894	5.4%
8- Infeccious and Parasite D.	46,533	5.4%
9- Perinatal Period D.	32,040	3.7%
10- Other causes	59,177	6.8%
Total Deaths from Unknown Causes	**868,906**	**86.7%**
3- Not well defined causes	133,434	13.3%
Total Deaths	**1,002,340**	**100,0%**

Source: SIM/MS Organized by: CGDANT/DASIS/SVS/MS

Table 2:
Deaths due to Cardiovascular Diseases, Brazil and Regions, 2003

	North	*Northeast*	*Southeast*	*South*	*Midwest*	***Total***	***%***
Cardiovascular Diseases	*10,106*	*56,392*	*141,398*	*48,978*	*17,194*	***274,068***	*100,0%*
Cerebrovascular Diseases	3,913	20,500	43,082	16,307	5,227	**89,029**	325%
Ischemic Heart Diseases	2,411	14,705	45,156	16,293	4,629	**83,194**	30.4%
Acute Myocardial Infarct	2,016	12,116	33,053	12,071	3,473	**62,729**	22.9%
Hypertensive Diseases	1,113	6,934	14,026	3,921	1,850	**27,844**	10.2%
Congestive heart insufficiency	1,248	6,708	12,320	5,001	1,887	**27,164**	9.9%
Other circulatory system diseases	542	2,717	6,819	2,182	942	**13,202**	4.8%
Cardiomiyopaties	343	2,206	7,554	1,517	1,326	**12,946**	4.7%
Arterial D. (includes aneurysm)	191	1,286	6,148	1,848	687	**10,160**	3.7%
Cardiopneumatic and pulmon. vase D.	199	719	3,521	1,020	296	**5,755**	2.1%
Arrythmias	146	617	2,772	889	350	**4,774**	1.7%

Source: SIM/MS Organized by: CGDANT/DASIS/SVS/MS

In the last decades, CNCD prevention became a concern for the public power and for different international organizations, due to the democratic transition Brazil has been experiencing, and the increase of the elder population (table 3) and the high incidence of such diseases in this segment of the population.

Table 3:
Number and Increase (%) of Elderly in the Brazilian Population from 1991 to 2000, by Age Group

Age Group	Year		Increase	
	1991	*2000*	*nº*	*%*
60–69	6.412.918	8.182.035	1.769.117	27,6
70–79	3.180.136	4.521.889	1.341.753	42,2
Over 80	1.129.651	1.832.105	702.454	62,2
Total > 60	10.722.705	14.536.029	3.813.324	35,6
Total Population	**146.825.475**	**169.799.170**	**22.973.695**	**13,52**

Source: IBGE: by DATA US/MS
Organized by: CGDANT/DASIS/SVS/MS

CNCD prevention and management strategies and actions have been developed in Brazil for almost a century (Brasil, Ministry of Health, 2002). However, such actions are fragmented within the institutions, being organized and conducted by different ministries, without a common link to join them, what may cause superimposition of efforts and reduction of the efficiency and effectiveness of the interventions.

Thus, by recognizing the complexity intrinsic to CNCDs and the resulting impact for the Single Health System of a possible epidemic of these diseases, including in what concerns the funding of assistential actions, it becomes evident that there is a need to make an extended and careful public debate on the formulation of a National Policy for Prevention and Control of Chronic Noncommunicable Diseases.

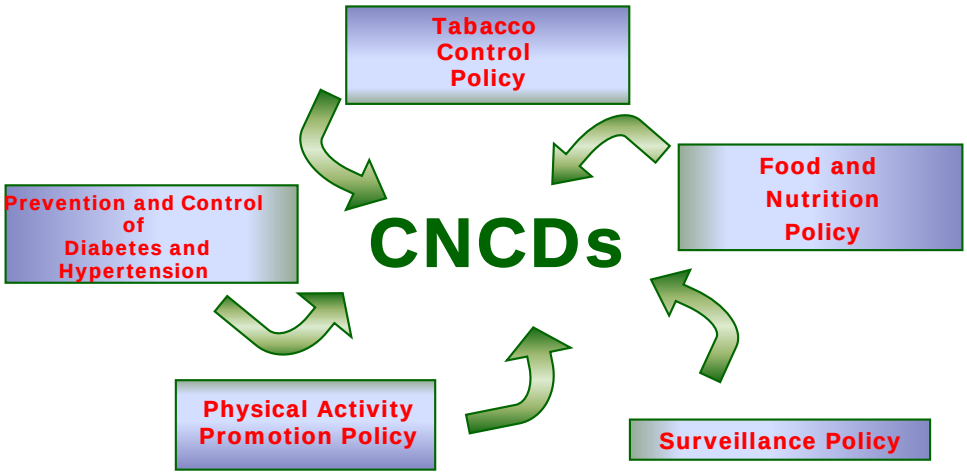
Due to these concerns, the project was conceived based on a huge participative process involving the Ministry of Health, the Observatory of CNCD Surveillance, the Prevention and Control Policy (OPDCNT), the Pan American Health Organization (PAHO), the Canadian Health Agency and Cooperation Centers in Brazilian universities.

The main objective of the proposal is to classify and analyse the governmental public policies formulation process for CNCD prevention and control in a federal sphere i in five fundamental basis in the public health area:

1. National Policy on Food and Nutrition;
2. National Policy against Smoking;
3. Diabetes and Hypertension Watch;
4. Physical Activity;
5. Surveillance,

according to the following design:

Brazilian Case Study: 5 Analysis Axis



Secretaria de Vigilância em Saúde

Ministério da Saúde

The analysis mentioned comprised the decision taking process to formulate these initiatives within the different sectors of the Ministry of Health. It occurs because, if all governmental programs have a technical performance content of an action proposal, according to rational criteria, all of them have a political content. Governmental actions and/or programs are carried out in a highly political environment.

Public power intervention in the social reality is too complex. The formulation of governmental policies and/or programs depends on the interaction of inland political groups and of their interaction with the organized society. Therefore there is a need to consider the political burden of the governmental actions in the analysis of governmental programs, especially when the objective is to analyze the governmental public policies formulation process.

The Observatory of Policies was implemented aiming at contributing to the technical capacity to analyze and evaluate CNCD prevention policies in Latin America and the Caribbean. It was responsible for the classification and analysis, with methodologic accuracy, of the information regarding the policies involved in the chronic noncommunicable diseases prevention. “This Observatory will be able to evaluate the evolution of the interventions in the region and will be in charge of divulging the results of the analysis as well as other relevant results” (PAHO, 2003).

In this context, WHO in partnership with the Collaborating Center of Canada for the development of chronic noncommunicable diseases prevention policies is undertaking case studies focusing on the formulation and implementation of policies in three countries: Brazil, Costa Rica, and Canada.

In Brazil, the design of the Observatory involved the process of analysing public health policies on CNCDs. This research is inserted within the scope of this proposal.

The research tried to answer the following investigation issues:

- How governmental initiatives for CNCD control and prevention are inserted in a more global future strategy to face this problem?
- How these initiatives can provide inputs for the formulation of an integrated public policy for CNCD prevention and control in Brazil?

2. Objectives of the Brazilian Case Study

- Outlining the initiatives for chronic noncommunicable diseases prevention in Brazil regarding smoking prevention, promotion of physical activities, diabetes and hypertension watch, food and nutrition policy and CNCD surveillance;
- Analyzing the process to formulate these public actions initiatives with a view to protect and promote health;
- Analyzing how such initiatives may be included in a more global future strategy to face this problem and to formulate an integrated policy for CNCD prevention and control in Brazil?
- Identifying elements that facilitate or impair the formulation and approval of policies in this area;
- Subsidizing the formulation of an integrated policy for CNCD prevention and control in Brazil;
- Analyzing the Brazilian results compared to the CNCD prevention and control policies formulation processes in Costa Rica and Canada.

3. Theoretical-Methodological Approach

For a better identification of the research instruments, it is necessary to understand the meaning of a given public policy analysis. There is only little concensus on this and, thus, the analist is induced to declare, from the beginning, what are his/her preferences and choices (Draibe, 2001).

For public policy analysis we understand the evaluation of the institutional engineering and the main features of the programs. Every public policy may be formulated and implemented in several ways. The option for a given formulation and implementation—under the point of view of funding ways, modalities of service

rendering, public and private sectors relationship, etc.—instead of another, is the object of study of the analysis in which one intends to rebuild the different characteristics to perceive them as a coherent and understandable unit.

However, although the analysis of a given public policy may assign some of the possible results to a given institutional design, only the evaluation of this policy may assign a causal relationship between a given modality of public action and the success or failure in the performance of its objectives. Or even to the relationship between this action and a given result or impact on the social situation before it is accomplished (idem).

Sônia Draibe (2001, p. 12) affirms that:

> "Policies and programs are alive. They are born, grow up, transform and reshape. Eventually, they stop; sometimes they die. They pass through a life cycle, a development or maturation process and, sometimes, an aging or weakness process (...) But policies and programs are made of flesh and bones, or even better, of body and soul. They are decided and prepared by people, are directed at people and their habitat. They are managed and implemented by people and, when this occurs, they are also evaluated by people. People and groups of people that give life to these policies act according to their values, concerns, options and perspectives. And they are neither consensual nor unanimous, as we know. On the contrary, the field where policies and programs flourish may be considered a field of strengths, debates, conflicts, that happen and are 'solved' with the lapse of time".

Political contents of policies compose what could be called a political economy of public policies (DRAIBE, 2001), since they refer to the meaning and logic of programs dynamics, moved by concerns, conflicts and eventual negotiations. This is the time policies are formed and formulated, when the initial decisions are taken and the strategies of actions are defined.

Although such processes are interdependent, a more delimited conception of the stages of a policy distinguishes at least two specific moments before the implementation. The formation phase implies the build up of an agenda, the definition of

the concerns and the identification of alternatives. The formulation phase is the moment when different proposals are transformed in the policy itself, by means of goals, objectives and resources definition and the announcement of policy development strategies.

Inasmuch as various authors deal with the evaluation and analysis of public policies used in this Project, two important stages in the life cycle of governmental programs are distinguished: the pre-decision phase, built by the public agenda and the confrontation of processes for alternatives formation, and the decision phase formed by the decisions authorized by governmental agents concerning program formulation.

Pre-decisional and decisional processes of a given policy or program are very complex and tend to be long. Theoretically, the first phase includes the formation of a public agenda (introduction of the subject or, more specifically, of the demands in the social agenda and, subsequently, in the public agenda); the production and comparison of alternatives by different groups of actors; the selection processes and their appropriation by the agents, according to the organization's legacy or its traditions and cultures. The second phase refers to the formulation, built mainly by the decisions taken regarding characteristics such as temporal dimension of actions, strategic actors to be involved in the support to the development of policies, goals to be reached, scope of the actions, resources available that result in laws, decrees, provisory measures, regulations, etc.

The conception of a program cycle composed by phases or stages was adopted for methodological systematization purposes, since, although there are characteristics inherent to certain cycles, it is difficult to completely separate them, because the actors involved are dynamic and creative.

The description of the methodology used is essencial to understand the steps that must be followed to develop a case study: analysis for the establishment of a public agenda, identification of proposals comparison, definition of CNCD prevention and

control policies or strategies in the five basis described, explaining their conception, scope and objectives.

The reconstruction of the formation and formulation processes of the initiatives to be analised considers the existence of a series of decisions, taken by different actors, who influence and conduct the actions configuration as proposed.

According to Castro (2000, p. 2):

> "It is accepted that, along the process, different actors coexist. They plan and act from different perspectives according to the understanding and interpretation of the reality corresponding to their needs and to the different abilities they have, given by the power resources they control. In the articulation processes the actors face and organize (or do not organize), in a mutual agreement, the decisions on political interactions, decision making arenas, around the maintenance and/or increase of the room for resources control available to the State. In each of these decision making arenas are defined the centers for deciding on the policies being formulated and implemented".

We will use the conceptual model by John W. Kingdom (1995) to analyse the formulation process of public policies, the object of our research.

Kingdon focuses on understanding the main pre-decisional processes for the implementation of a social policy: establishment of an agenda and specification of alternatives. The governmental agenda consists of a list of items to which governmental authorities are paying some attention in a given moment. The process of alternatives specification is that in which some options are actually selected, within a group of feasible alternatives.

Governmental Agenda

In this appraisal process area defined three inter-related stages: problems, policies and politics. Social actors recognize the problems, make proposal to reformulate public policies and engage in political activities, such as electoral campaigns and

political actions by pressure groups. Each participant—president, members of the Congress, public servants, lobbyists, journalists, university professors, etc.—may, at first, be involved in one of the three processes (recognition of the problems, development of proposals and politics).

Problems: The recognition of problems is a crucial moment for the definition of an agenda. As the agenda is established, the possibilities of a topic or proposal are notably strengthened if they are linked to an important problem that, in a way, violates common values.

Politics: The second explanation for the high or low incidence of topics in the agenda is the political current. Independent from the recognition of problems or the development of political proposals, political events flow according to a dynamic and to its own rules. The actors notice changes in the national politics environment, the elections bring new administrations and new parties or ideological configurations to the Congress and the different pressure groups impose (or fail in imposing) their demands on the government.

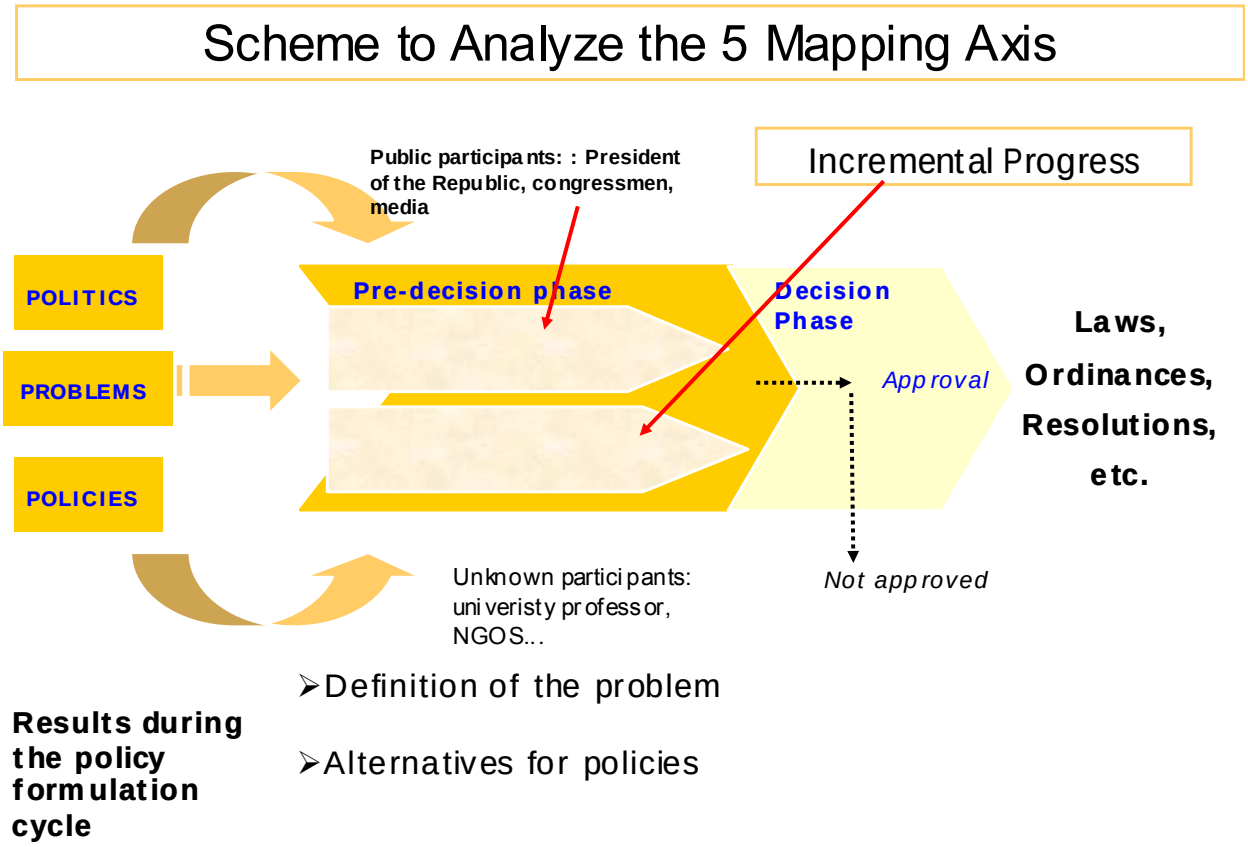
Public participants: In the third place, the public participants, those who receive a considerable pressure and public attention, including the President of the Republic, high-level workers, members of the Congress, mass media and actors related to electoral processes such as political parties and political campaign directors also influence in the formation of the agenda.

Specifying Alternatives: The alternatives are created and set out in the current of policies, with the participation of relatively unknown actors.

Policies: The formation of policy alternatives is understood as a selection process. It is a “wave” of policies. Many ideas appear, conflicting with each other, finding new ideas and proposing new combinations and recombinations. The origin of policies may seem obscure, difficult to understand and to organize.

Unknown Participants: The alternatives and solutions are produced within communities of experts. This group is comprised of university professors, non-governmental organizations (NGOs), courts and analists. Their work is expressed in the planning and evaluation or in the negotiations proposed to the members of the Congress. The proposals are discussed by means of bills, audiences in the Congress, issue of articles, etc.

The analysis guide proposed by Kingdon (1995) may be schematized as follows:



Sc

According to Kingdon (1995), the three flows—politics, problems and policies—and the types of participants have specific dynamics and may act by impulse or limitation so that a problem/alternative is included in the agenda. When the three flows join, forming what the author calls “interlock”, the possibility that the problems and alternatives are included in the decision phase (decision agenda) increases significantly.

At the decision taking moment, public participants—formed by the president, ministers, high-level workers and congressmen—assume a central role although the unknown participants also participate. At this stage, are taken decisions authorized by formal mechanisms (laws, decrees, provisory measures, resolutions), authority is delegated, obligations and rights are established and resources are granted using public authority.

Based on the description of the events regarding this issue, four main questions must be answered:

- How and since when the CNCD issue was included in the agenda of the Brazilian government?
- Which are the alternatives of solution proposed by the several governmental actors for the CNCD prevention and control problem?
- Which were the options of policies, programs and actions selected to face the problem?
- Why certain alternatives of solution, by means of policies, programs and/or actions, were privileged?

4. Methodological Procedures

This is a qualitative research project aimed at understanding the interpretations of the actors on the formulation process for public policies on health promotion, which may contribute to the formulation of an integrated policy in CNCD surveillance, prevention and control.

The most used method was the comparative case study among empirical analysis units selected by the members of the Observatory on Policies. These units are:

a. smoking prevention;
b. promotion of physical activity;
c. diabetes and hypertension watch;

d. National Policy on Food and Nutrition;
e. CNCD surveillance.

In this report are presented the results of a single case (National Policy on Food and Nutrition) since the other axis of the research design will be organized lately, according to the schedule of the Observatory of Policies, Brazilian case study.

These analysis unities were chosen for the great contribution they may give to the prevention of chronic noncommunicable diseases (BRASIL, MINISTRY OF HEALTH, 2002), according to the Brazilian reality.

For Yin (2005), “normaly, the case studies are more important when questions such as “when” and “why” will be answered, in situations in which the researcher has little control over the case and when the focus is placed on contemporary events included in a certain context of the real life” (p.19), especially when the “limits between event and context are not clearly defined” (p.32).

4.1 Analysis Unit: National Policy on Food and Nutrition

Since the method defined was the case study, the establishment of the analysis unit corresponds to the “case” definition to be studied (YIN, 1984, apud ALVES-MAZZOTTI AND GEWANDSZNAJDER, 1998).

Different aspects were considered to choose the National Policy on Food and Nutrition (PNAN) as a comparative study analysis unit:

I. it is a Federal Government guideline, with multisectorial character, under the joint responsibility of the Ministry of Health, the Ministry of Planning, Budget and Management, the Ministry of Social Development and Combat to Hunger, the Ministry of Education, among others;

II. PNAN is coherent with the national objectives regarding CNCDs,
III. it is a sectorial policy with national scope;
IV. it involves one of the main factors for the protection of CNCDs, that is: the promotion of a healthy nourishment;
V. PNAN has an intersectorial component with other governmental public policies, which give it an universality potential.

In June 1999, the Ministry of Health by means of Directive No.. 710, approved the National Policy on Food and Nutrition, part of the National Health Policy, also included in the context of Food and Nutrition Security (SAN) (SAÚDE, 2003).

PNAN formulation was coordinated by the former Health Policies Secretariat and with the participation of government sectors, society segments and experts in the issue. It was subject to the appraisal of the Tripartite Intermanagers Commission and the National Health Council.

PNAN and other governmental initiatives belong to the "group of governmental policies for the accomplishment of the universal human right to adequate food and nutrition" (BRASIL, MINISTRY OF HEALTH, 2003, p. 17).

PNAN political-institutional guidelines (BRASIL, MINISTRY OF HEALTH, 2003, P. 19) were defined to reach its purposes:

- encourage intersectorial actions for the universal access to food;
- guarantee food security and quality and services rendering within this context;
- monitor the food and nutritional situation in Brazil;
- promote healthy feeding practices and life style;
- prevent and control nutritional disorders and diseases associated to feeding and nutrition;
- promote the development of investigation lines;
- develop and qualify human resources.

The investigative questions that oriented the analysis of PNAN formulation processes were the following:

- ➔ Which social, institutional and political contexts viabilized PNAN formulation process?
- ➔ How, within PNAN scope, the prevention of CNCDs was included in the public agenda?
- ➔ Which collective health problems started this initiative?
- ➔ Which are the alternatives of solutions proposed by the different governmental and non-governmental actors to face this problem?

To answer these basic questions and to reach the objectives of the research were used secondary and primary data sources.

4.2.1 Secondary Data

Secondary data regarding the dimension of problems related to the five axis and analysis units were raised, such as:

- Laws that created and ruled the actions and programs analysed;
- Presidential decrees, directives, plans, bulletins, reports issued by the qualified governmental organisms;
- Publications of international organizations;
- Articles in national newspapers;
- Speeches, reports, opinions;
- Minutes of inter-ministerial and intra-ministerial meetings, work groups;
- Memories of events organized;
- Others.

4.2.2 Primary Data

Sixteen semi-structured interviews with key actors were done, based on an interview guide (Annex 2), using the following selection criteria:

- Indication of participants by the Observatory of Policies on Chronic noncommunicable Diseases;
- Public managers that participated in the PNAN formulation process in various sectors of the public politics;
- Experts in scientific evidences of health epidemiologic basis related to food and nutrition;
- Experts in food and nutrition with proved experience in the formulation of food and nutritional programs and actions.

Key-actors indicated by the Observatory of Policies on chronic noncommunicable diseases in Brazil, who took part or still take part in the following governmental institutions: General Coordination of Food and Nutrition Policy (CGPAN/MS); General Coordination of Noncommunicable Diseases and Illnesses (CGDANT/MS); Applied Economics Research Institute (IPEA/MP); Oswaldo Cruz Foundation (FIOCRUZ/MS); Ministry of Science and Technology; National School of Public Health (ENSP); Pernambuco Federal University (UFPE); Bahia Federal University (UFBA) and São Paulo University (USP). A technician from the World Health Organization (WHO/Geneva) and a key informant linked to the non-governmental organization called Brazilian Association on Food and Nutritoin and Human Rights (ABRANDH) were also interviewed.

The interviews with governmental and non-governmental actors involved in the public agenda formation and actions/programs formulation stages, allowed for the restoration of the process and the movement of the actors, as well as for their motivations and concerns in the food and nutrition areas in Brazil.

Interviews were done by a team of four assistant researchers of the main researcher linked to this group. The researchers were trained on ethical, theoretical and methodological aspects of data collection procedures in qualitative research, mainly in what concerns the relationship between researcher and interviewee, the reciprocity

relation and the moments of understanding and explanation both on the part of the interviewee and the researcher on the issues interpreted.

In order to comply with the resolution of the National Commission on Ethics in Research (CONEP) of the National Health Council, the process was duly forwarded by the Health Surveillance Secretariat of the Ministry of Health to the regulating court. Thus, each key informant invited to participate in the research was requested to sign the “Free and Informed Consent Term” (TCLE), as recommended by CONEP/MS norms (Annex 3). Still regarding ethical aspects of the research, we should say that the names of the interviewees were omitted to protect their identities as usual in qualitative researches.

4.3 Organization and Systematization of Discourses/Reports of Key Informants

The qualitative methodology establishes some key-issues during the organization of the studied object and the theoretical-methodologic mediations selected, among which are: by means of open interviews, with the group of different social actors interviewed involved in CNCD prevention, how could these basic questions on the research objects be answered?; how to interpret the significance of the experiences and practices of the subjects within the open interviews point of view?; how the subjectivities, inherent to the subjects, may be considered scientific knowledge?

To understand the complexity of CNCD prevention policies, programs and projects formulation processes it was necessary to transcribe all the recorded interviews, maintaining the speeches uniformity and preserving the context in which the discourse is produced. These elements bear a specific meaning for both interviewee and interviewer.

The interpretation of qualitative data, collected with semi-structured interviews was developed in phases, using the “content analysis” method developed by Bardin (1979). It comprises a series of communication analysis techniques aiming at obtaining the contents given by the interviewees in between lines, those declared or not declared,

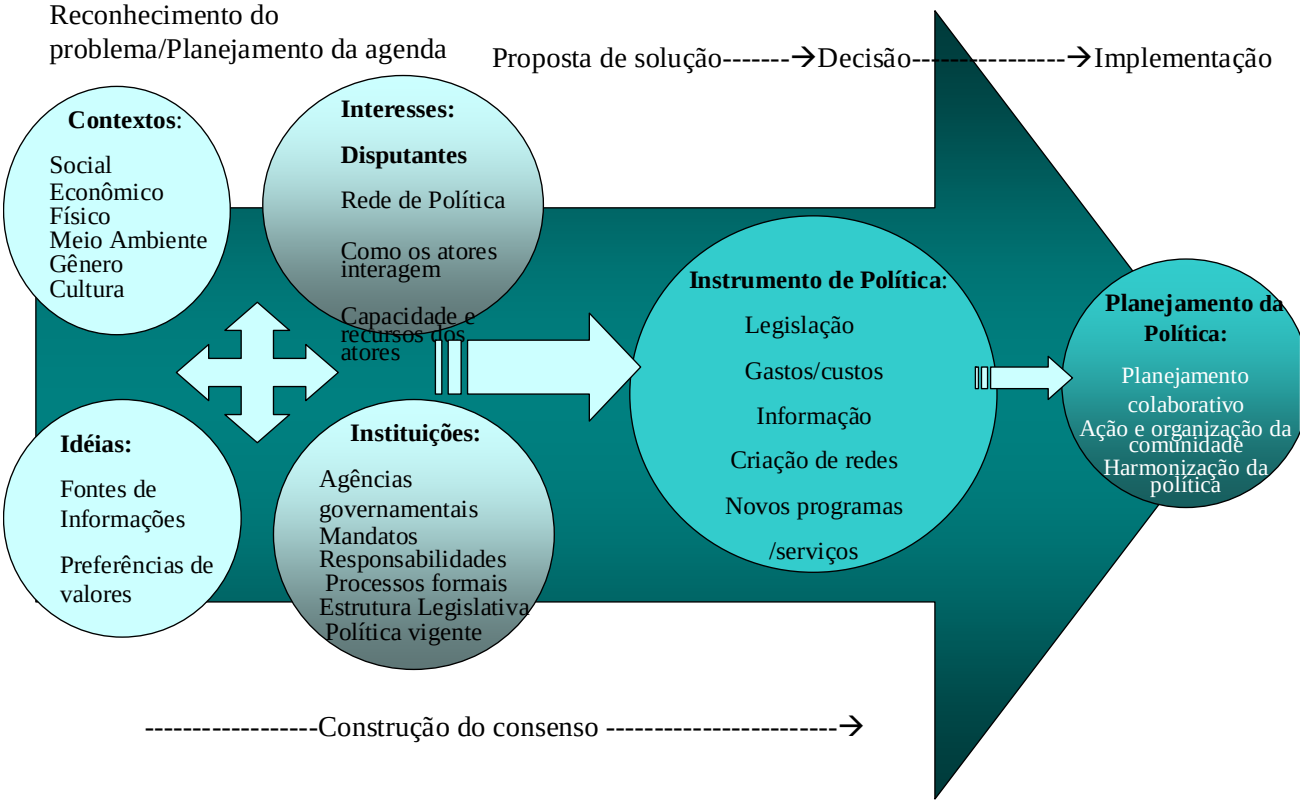
that is, the manifested or concealed meanings, using a qualitative material. Beginning with the research objectives and the thematic content analysis technique (search for more recurrent themes and meanings in the speeches of the interviewees) the following procedures of primary data were done:

1. ***Full transcript of recorded interviews,*** aiming at doing a first analysis of the content;
2. ***Corpus build-up and preservation of the discoursive structure:*** Aimed at protecting the interviews context and uniformity. This phase consists of grouping interviews, aiming at organizing the speeches according to research objectives and qualitative axis and the dimensions of the interview guide. In this phase were listed the analysis categories, each corresponding to a question in the interview guide (annex 2). It consists of the information organization phase (MINAYO, 1996) aiming at complying with some norms of legitimacy, such as: a) exhaustivity of the matter (if the corpus represents all the aspects of the interview guide); b) representativity (if the corpus represents the actors group of speeches); c) relevance (if the analysed data are adequate to the objective of the research).
3. ***Data interpretation based on the analytical chart*** (*framework)* organized by the Policy Observatory, as will be shown in the following item.

4.4 Structure to Analysze the Development of the National Policy on Food and Nutrition

The Canadian Collaboration Center with the contribution of Brazilian and Costa Rican teams organized, from January to November 2005, the analysis chart aiming at subsidizing the public policies analysis selected for study at the Observatory. Five interconnected categories of factors were created: context, ideas, institutions, concerns and political instruments (CLOTTEY, 2005), according to the following diagram:

Estrutura para analisar o processo de desenvolvimento da política



4.4.1 Context

The context refers to the external environment of the policy formulation process from which situations, information and pressures arise. Influences may be of international, national or regional scope, with political, social or regional characteristics and, many of them are out of the policy formulator control. Evidences of precarious or alarming health conditions in the population or of epidemics or possible pandemics recently influenced a serious reconsideration of the public health policy in many countries, aiming at dealing with communicable and chronic noncommunicable diseases.

The focus, thus, must be given to PNAN formulation processes in Brazil, enriching the structure and the political, economic, social and cultural contexts. In the

Brazilian interview guide the key-issue necessary to raise the contexts is as follows: “In your opinion, which national and international factors (economic, social and political) influenced the inclusion of food and nutrition in the public agenda and the formulation of the National Policy on Food and Nutrition in 1999”?

4.4.2 Ideas

The ideas refer to the preferences of the governmental and non-governmental actors involved in the PNAN formulation process. The Brazilian interview guide gives priority to the following issues:

a. In your opinion, in which moment did the problem regarding food and nutrition was first included in the Brazilian public agenda?
b. Who were the actors that contributed, in some extent, to the formation of the agenda and, consequently, to PNAN formulation?
c. Among the actors involved and the alternatives of solution, is there any reivindication or sector that was not considered?

4.4.3 Concerns

The analysis of agenda formation and public policy formulation processes priorizing the interests and conflicts tries to influence pressure groups, the interaction among the main actors of the process, the argumentation hability and the negotiation of concerns and conflicts. These converge to the choice of a certain alternative of solution, in the specific economic, political, institutional and social contexts. Three questions were selected in the Brazilian interview guide, with a view to understand the interests and disputes of the actors in the food and nutrition area: a) Did other public policy sectors, besides the health sector, participate in the debates regarding PNAN formulation?; b) which are PNAN weaknesses, for CNCD prevention and control?; c) which are PNAN merits for CNCD surveillance, prevention and control?

4.4.4 Institutions

It concerns attracting governmental and non-governmental institutions, with mandates, leaderships and formal decision taking structures in the National Policy on Food and Nutrition formulation process. Thus, the Brazilian interview guide highlights three relevant issues: a) Which priority level was given to CNCD prevention and control guidelines associated to food and nutrition?; b) Before the creation of PNAN, were there programs, actions and services implemented with a view to prevent and control chronic noncommunicable diseases? c) which were the results of these programs and actions?

4.4.5 Political Instruments and Action Plans

In the Brazilian case, the focus on political instruments and actions plans refer to the group of laws, regulations, new programs and services put into practice by the government for the development of a National Policy on Food and Nutrition. The basic issues that comprise this analysis axis are:

a. Which plans, programs and services were formulated and put into practice by the government to deal with the food and nutrition issue in the 1999-2005 period?
b. Which factors and political, economic and social situations influenced the choice of instruments and action plans?

4.4.6 Interests, Ideas, Institutions and the Formation of "Public Policy Communities"

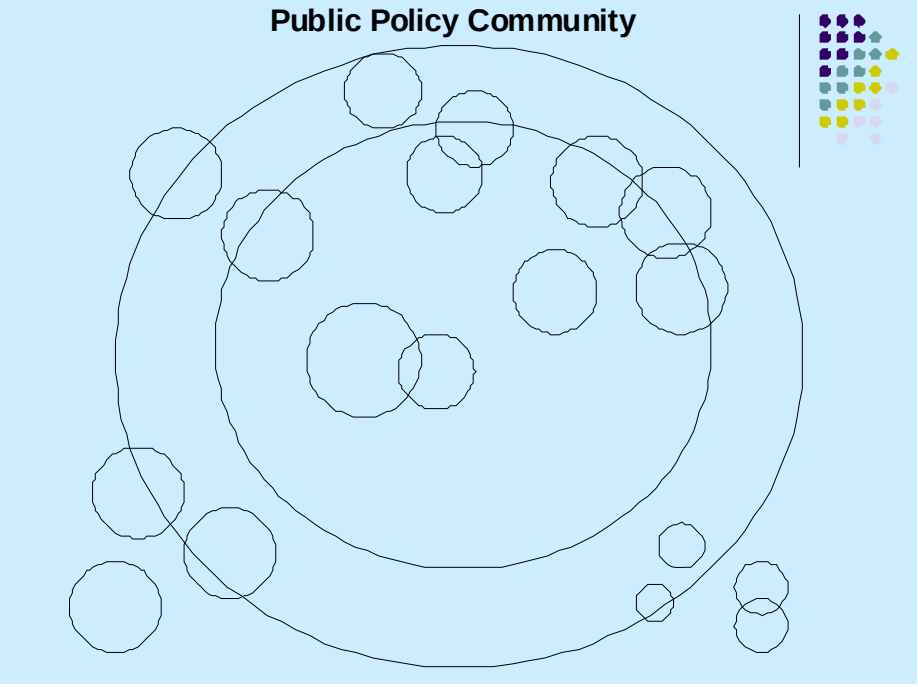
According to Merrien (2000) in the State scope, there are sectors and sub-sectors that cooperate with the public policies organization and implementation process together with civil society groups, forming, thus, a political network.

According to the author, the use of the network idea reveals a dialetic movement between State and civil society interested in formulating and implementing public

policies in a given intervention area. That is, there are not only two monolithic blocks, but sectors and sub-sectors of the State block and the civil society block and between them there are more or less institutionalized networks, indicating the existence of public policies communities.

Still according to Merrien (2001, p. 65), the public policies communities are built by actors with a direct or indirect interest in the object of politics: for example, health, social welfare, education, agriculture, food and nutrition, among others. Public policies community members are not necessarily organized in networks, even though there are some networks. Thus, it is necessary to discern the “public policies networks” formed by members of one or another public policy community that interact in the debate on ideas and interests for a public policy object in a given area. The communities of policies demonstrate common interests for certain problems and defend alternatives for solution of problems according to their ideas, values, institutions and strategies. They meet and establish a way to collaborate in order to obtain profits on the interests they defend and, at last, they form “epistemic communities” with a specific language to interprete problems of the public policy, to establish an agenda and to find alternatives of solutions.

Based on this conceptual definition of community of public policies, a bubble diagram (VOGEL, 2005) will be used to identify the ideas, interests and institutions to formulate the National Policy on Food and Nutrition in Brazil.



4.5 Sources of Complementary Data

Analysis and interpretations were complemented by other data sources:

- Records of seminars organized in Brasilia from October 2004 to August 2005, aiming at following the political and technical discussion for the structuration of the CNCD Prevention Policies Observatory in Brazil.
- Continue the bibliographic research survey in the health and social sciences scope, about theoric, conceptual and methodologic aspects involving the object of study. Literature survey done in all phases of the research.

5. Previous History of Action Formulation and Implementation Processes to Face Problems Regarding Food and Nutrition in Brazil

5.1 From Hunger as a Social Issue to the Technical-Scientific Approach to Hunger (1930–1984)

The food and nutrition issue in Brazil entered the national public agenda in different political, economic and historic situations. The first moment this subject was discussed as a necessity, was with the publication in 1946 of the first issue of the Geography and Hunger Magazine (CASTRO, 1946) whose author was the scientist, doctor, professor and politician Josué de Castro. This work establishes the beginning of the denounces on this critical Brazilian calamity and warns that the hunger issue is not only a biologic, but also a social event.

According to Arruda (2005), in the 1930's was done an investigation about the "worker class life conditions", coordinated by Josué de Castro, under the auspices of the Public Health Department of Pernambuco State.

An interviewee declares that the food and nutrition issue entered the Brazilian public agenda between 1938 and 1940, when the minimum wage was defined, in a great extent by the influence of Josué de Castro. The minimum wage considered the basic budget of a family, 50% of which on expenses with food, which at that time was enough to buy 12 food items.

> I believe this [creation of the minimum wage] was the first point. Shortly after that, was created in Brazil the School Lunch. Some isolated initiatives were also taken in an extremely experimental character, on specific problems to combat anemia. Thus, I consider that, historically, Brazil inaugurated in great style the food and nutrition policy by implementing the legislation that established the minimum wage.

With a study on public policies regarding hunger in Brazil, Bonfim (2004) tried to recover the path followed by governmental actions.

The social nutrition project in the Brazilian State—although not comprised by formal plans, but by isolated attempts until 1973 with the creation of the First National Program on Food and Nutrition (PRONAN)—results from the planning of the new economic order between the 1930`s and the 1940`s when the Brazilian economy changes from a phase of agricultural exportation to an urban-industrial phase. The historic boundary of specific interventions in the nutrition area in Brazil was the 1930`s, as emphasized by Escoda (1983):

> (...) In the Vargas government, in a populist context, social policy experiences start being implemented in this area. An example of that is the explicit concern of the State with nutritional needs of the "adult worker represented by Decree-Law No.. 399 30 of April 1938" (p.90).

The historic investigation done by Vasconcelos (2005) emphasizes three key-periods in the construction of a public agenda and public policies on the food and nutrition issue. The first period—1930 to 1963—corresponds to the moment when social policies regarding this issue emerged. The greatest influence here was linked to the studies of Josué de Castro. The second period—1964 to 1984—corresponds to the attempts to incorporate nutritional and economic planning techniques, conducted by the National Institute on Nutrition and Food (INAN). The third period—1985 to 2003 (included in the study specified by this author) has been linked to attempts to democratize and modernize the Brazilian society, as well as to the search for alternatives.

Between 1940 and 1967, when the country was forced to grow following the example of countries emerging from deep structural and economic changes in the post war period, it was necessary to promote plans for the nutritional improvement of the population, following the developmental theory of that time. Thus, the Federal Government created on 5 August 1940, by Decree/Law No. 2.478, the Social Welfare Food Service (SAPS) initially aiming at assurring favorable and hygienic food conditions for retired and pension funds secured people subordinated to the Ministry of Labor, Industry and Commerce.

While this law was in force, it promoted the following actions:

1. The first popular restaurants were installed in Rio de Janeiro and São Paulo States and other cities, aiming at offering urban workers a balanced low cost meal;
2. Subsistence stations were created with a view to sell first need foodstuff with subsidized costs.
3. Educational actions were implemented to encourage healthy nutrition habits and the improvement of the nutritional condition among the population;
4. Promotion of trainning courses, human resources formation and accomplishment of studies and researches in this area (VASCONCELOS, 2005).

In the governments after 1940, when SAPS was created (Gaspar Dutra [1946-1950] implemented SALTE Plan [health, food, transport and energy], Getúlio Vargas [1951-1954] returned the populism, Juscelino Kubitschek [1955-1960] implemented the Goals Plan and João Goulart's [1961-march 1964] implemented the basic reforms) the issue on the State intervention on food and nutrition came true with the continuation of SAPS actions. It occurred with the creation in 1954 of the National Program for School Nutrition (PNAE) and the beginning of the nutritional care program for pregnant women, nursing women and children under five years of age developed by the National Food Commission (CNA) assigned to the Ministry of Health.

These programs were closely related to international organizations and to international food support programs created after the Second World War.

At the beginning of the 1960s, Rio Grande do Norte implements state nutritional programs. It was the Integrated Plan on Food and Nutrition which launched the structure of multisectorial nutritional planning including similar components on health, education and food production in the program. This program had a wide participation in the populist fundamentals of the moment and was assisted by the educational scope with Paulo Freire method. This was under the responsibility of the National Foundation of Public Health Services (FSESP) in an agreement with the state health and agriculture secretariats.

The Brazilian experience of official programs on food and nutrition at national scope may be highlighted with the following examples:

- SAPS (Social Security Food Service) was created in 1955 under Café Filho's Government. It promoted a low cost basic food supply to social workers and contribution to the formation of human resources specialized in nutrition, organizing courses for nutritionists in Rio de Janeiro. As of 26 September 1962, by Delegate Law No. 6, SAPS was transformed in the Brazilian Food Supply Company (COBAL), a company responsible for 'low-cost' food supply by means of grocery stores designed to serve the overall population.

- SNME (National Service for School Lunch) was created by Decree No.. 37,106, of 31 March 1955, still under the government of President Café Filho and aimed at supplementing school nutrition, at first with food donated by the American surplus production. Law No. 480 of 1954 (Agricultural Trade Development and Assistance Act) established the norms for such surpluses. In 1974, the American Congress discontinued these donations with the argument that Brazil was already producing enough food for the country and had also won a bid to export soy to the United States As from that date the food destined for school lunch was reputedly from Brazilian origin. In 1967, SNME was renamed CNAE (National Commission on School Nutrition) which continued developing in a permanent basis the program for school nutritional supplementation. However, in December 1981, CNAE was transformed in the National Institute for Student Welfare (INAE) which assumed the same activities attributed to CNAE including PRONAN food supplementation line.
- The National Institute for Student Welfare (INAN) was created in 1972, during Médici government (1970/1974) with the purpose of supporting the government in the formulation of a food and nutritional policy. This organism was created by Law No. 5.929, of 30 November 1972, being converted into a state company linked to the Ministry of Health, by means of Decree No. 73.996, of 30 April 30 1973, and worked as the main organism for support and coordination in this area.

In synthesis, from the beginning of the 1940s to the first years of the 1960s, there were improvements as to a wider conception regarding the food issue.

With the establishment of the dictatorial regimen as from 1964, the disputing discourse of the nutritional social current is substituted by a technical-scientific approach, justified by the terms rationality/efficiency. In fact, in the periods of 1964-1966 with the Economic Action Plan (PAE); of 1967–1969 with the Development Strategic Plan (PED) and of 1970–1972 with the Goals and Basis Plan for Governmental Action,

nutrition is not considered a specific item, being dealt as a problem regarding the health sector.

5.2 The National Institute on Food and Nutrition (INAN) and Their Respective Programs and Actions (1972–1984)

In 1972, the *Third Special Meeting of Health Ministries of the Americas* took place in Santiago, Chile, with the aim of making changes in the way social policies were handled in Latin America. It resulted in the development of the Ten-Year Plan for the Americas. The Brazilian government, at that time, was committed to the establishment of the main lines of the Food and Nutrition Policy. The Ten-Year Plan for the Americas meant a favorable political opportunity to include the food and nutrition issue within the context of the health area.

Due to the guidelines of the Ten-Year Plan on food and nutrition for the Americas INAN was created as a state company linked to the Ministry of Health, replacing the National Food Commission.

INAN formalized and included food and nutrition in the agenda in institutional terms, since the studies at that time (ENDEF and PNSN) showed high rates of infant mortality and malnutrition in Brazil. Among the objectives for the creation of the INAN are: i) to support the government in the formulation of the National Policy on Food and Nutrition / PNAN; ii) to formulate and propose the National Program on Food and Nutrition / PRONAN; iii) to promote the enforcement of PRONAN; iv) to supervise the implementation of PRONAN; v) to evaluate, from time to time, the results obtained; vi) to work as a central organism for food and nutrition activities in Brazil; vii) to act as an agency for development and national security, breaking with the purely international systems for food distribution that endangered the Brazilian security.

In 1973, Decree/Law No. 72.034 created PRONAN, which would last until 1974. It was a set of 12 subprograms forming the different governmental structures in a federal scope.

According to DINIZ (1988, pp. 14-15), the main programs and projects achieved by PRONAN were:

1. Complementary Nutrition Program;
2. Nutrition and Health Program, subsequently called Food Suplementation Program;
3. Program for the Rationalization of the Production and the Commercialization of Food, which assembled three specific projects, namely:
    a. Worker's Food Program (PAT);
    b. National Program of School Nutrition (food for pre-school and primary school children);
    c. Program for the Support of Pre-School Children, which supplemented the nourishment of children between four and six years of age.

The logic of PRONAN was to consider food supplementation as transitory, and as a specific protection to more vulnerable populational groups as well as a support for the small producer. This would be the main action of the program, since 70% of its basic food production in Brazil, at that time, came from these country workers, that would have the guarantee of the anticipated purchase and commercialization of their products by the former COBAL. COBAL, on its turn, would destinate the surplus to the supplementation line.

Another line of PRONAN created mechanisms to motivate the nutrition of company worker's nutrition and subsequently of country workers *(bóias-frias).* A fourth line would be the development of activities on the technology to enrich basic food products as specific protection measures to fight the most predominant nutritional deficiencies. It would also motivate nutritional research in the investigation of the characteristics of the Brazilian nutritional problems and its alternatives.

An important empiric evidence in the determination of PRONAN nature refers to the National Study on Familiar Expenses (ENDEF) of 1974-75. This research was done aiming at drafting the nutritional outline and mapping infant malnutrition. It was, thus, the first inquiry on food and nutrition on the Brazilian population, revealing, among others, the following results:

> Sixty-seven percent of the Brazilian population had a daily energetic intake lower than the minimum accepted by FAO. The Brazilian diet, even when insufficient in terms of energetic intake, it was balanced in what regards other nutrients. 46.1% of children under five years of age (56.5% in the Northeast region and 38.6% in South and Southeast regions) and 24.3% of adults presented malnutrition as to energetic/protein intake (Cf.MOISÉS, 2001).

In 1975, a new administrative management commences at INAN, which decided to make an agreement with the Economic and Applied Research Institute / IPEA— forming a technical team to make studies on food and nutrition and to define the II PRONAN, conceived as a guideline of the II National Development Plan (II PND). This plan aimed at reformulating the governmental view and action in the social area, according to three principles (II PND): i) hierarchic equity between social and economic developments; ii) special attention to low income groups; iii) shared responsibility of the social and economic areas for the solution of social problems.

In 1974 with the II PND, the Brazilian public health takes a leap forward into the search for reorganization followed by a country modernization process. INAN developed specific food and nutritional programs, PRONAN I and PRONAN II, foreseeing, in a certain way, the creation of a national policy in this area.

Thus, according to the testimony of a key-informant,

> Since 1974, Brazil had a formal policy on food and nutrition formed by the II PRONAN. By the way, it is curious that there was a II PRONAN without having had the first one, which a characteristic of our reality.

It was a period of economic opportunity in which Brazil (1974/1975) was living a considerable economic progress and, at the same time, a terribly unfavorable social situation. Thus, for political reasons, including of foreign nature, the World Bank granted a loan to Brazil and within this loan Brazill signed an explicit commitment to work on social issues, such as infant mortality and malnutrition—both highly predominant in Brazil, as shown by 1974/1975 studies.

Based on this requirement of international organizations and due to the social crisis and the need to legitimate the military government was established the National Policy on Food and Nutrition within the health area, under the responsibility of INAN (although it was a sectorial organism within the health area with a multifactorial interdisciplinary approach involving different ministries). Also because, according to a key-informant,

> INAN, within the structure of the Ministry of Health, was a foreign matter. Therefore, it was decided to creation a National Policy on Food and Nutrition, as a justification for the existence of this organism and as a way to institutionalize a commitment that should not be related only to the health sector.

At that time, the 1970s, a great effort was done to renew the governmental technical force, qualifying personnel to improve human health issues.

In 1976, the technical group of the IPEA National Center on Human Resources health sector (CNRH) was in charge of formulating the second version of the National Program on Food and Nutrition. Its main objective was to strengthen the small and medium producers and to develop precarious economic regions. Thus, PRONAN reflected an attempt to direct the health attention to preventive practices with a greater

efficiency and social content, acting in the less favorable groups, but with a wide scope to different age groups. According to Kruse (2004), the premises of the II PRONAN were:

1. to give priority to the users depending on their variable income (familiar income up to two minimum wages);
2. to give priority to the age groups more vulnerable to aggresions of nutritional deficiency (children, pregnant and breast-feeding women);
3. to give preference to traditional food;
4. to motivate small and medium rural producers;
5. to priorize actions in the Northeast region of Brazil.

Diniz (2001) affirms that it was a very wide governmental proposal which should be supported by a coordinate action of different sectorial policies, including the health and education areas, and not only by the traditional areas of food and nutrition.

As Malaquias Batista and Barbosa (1985, apud DINIZ, 2001) understand, the strategic functions of PRONAN programs and projects were supported by the economic policy valid at that time, added to INAN lack of political power to coordinate a broad sectorial policy in the food and nutrition areas, within PRONAN models.

In fact, by analysing the military government period, mainly that period comprising the II PND, 1975 to 1978, one can notice an expansion of the social policies due to the need to legitimate the government. The social policy, within the II PND, would be used as a strategy to reallocate income. This one comprised mainly three sectors: (1) Human Resources Valuation Program, such as: education, health, sanitation, nutrition, work and professinal training; (2) Social integration (PIS, PASEP), Housing and Social Security; (3) Urban Social Development (PEREIRA & PAIVA, 1981).

Thus, in this phase, the social policy was extended and was followed by programs and the respective implementation agencies, as demonstrated by Pereira and Paiva (1981). Among these are: the Employment Mediation Program (PIE) established by means of the National Employment System (SINE) in 1975; the National Program for the Development of Rural Communities (PRODECOR) in 1976; the National Program for Urban Social Centers (CSUs) in 1975; PRONAN in 1976; the Program for Interiorization of Health and Sanitation Services (PIASS) in the Northeast in 1976; the Mother-Infant Health Program (PSMI) in 1977; the Pre-school and Primary Students Service Program; the Children Welfare Program (PBEM) based on the Children National Policy guidelines (PNM) in 1977, among others.

In 1978, the *International Conference on Primary Health Care* took place in Canada, proclaiming the eight basic elements needed to offer health to everyone:

a. educate on the predominant health problems, their prevention and control;
b. promote adequate food supply and nutrition;
c. adequate water supply and basic sanitation;
d. mother-infant care, including familiar planning;
e. imunization against the main infectious diseases;
f. prevention and control of endemic diseases;
g. adequate treatment of common diseases and accidents;
h. distribution of basic medicine.

Thus, in the Food and Nutrition areas, III PRONAN never got to be implemented. It was planned for the 1982-1985 timeframe, and suggested inovative measures such as the creation of a National Fund on Food and Nutrition and the transformation of INAN into a public company: The II PRONAN existed until 1990, when it was virtuallly extinct (SILVA, 1995).

In what regards the analysis of the results reached by these programs, one can deduce that, since they did not overcome the purely assistential action, they had a perverse effect: they contributed to the maintenance of poverty, worsening social

inequalities, since they were not more than palliatives offered by technical-bureaucratic compounds commited to the logic of accumulation of social products (PEREIRA, 1987, PEREIRA & PAIVA, 1981).

To reinforce the above mentioned, Santos (1979) affirms that the social policy in Brazil, at that time, was “unconscious and segmented”, since the so-called preventive policies (income, health, education, basic sanitation) instead of solving the problems, helped intensifying them. It was then necessary to apply compensatory policies (social security, child welfare, food supplementation, etc.) which, by the other hand, could not comply with all the demands due to the extension of the social problems.

5.3 Democratic Transition and Food and Nutrition in Brazil: Problem, Agenda, and Alternative Solutions (1985–1989)

After this short overview on the historic course of the social policies in the previous periods, the questions are: after 1985, which were the social political duties of the Brazilian State in the scope of the democratic openness? Which were the form and the nature of the actions in the food and nutrition areas during this period?

In this short explanation, we do not aim at dealing with the political, economic and social tendencies that resulted in the so-called New Republic. We will focus especially in some contradictions of this process in regards to the social policies and their implications to worsen the contradictions of the 1990’s, mainly in the food and nutrition areas.

In the New Republic government, priority was given to the social area, at least apparently, as a way to redeem the social indebtedness accumulated in two decades of military government, which emphasized the economic growth. The baselines of the debates were the citizenship, the legal rights, the political and social rights issues and the role of the social policies as a strategy to face poverty and to reduce social inequalities and the probable “consistency between capitalism and democracy” (OFFE, 1984).

Official documents established the following objectives for social policies: *to eradicate the absolute poverty, to improve income distribution and to reduce social inequalities.* The synthesis of these objectives was expressed by the creation in an emergency character of the Social Priorities Program for 1985, whose resources were destined to the food, education, public health, safety, urban infrastructure and housing. The main objective was to “viabilize programs of most immediate nature aimed at starting the effort to fight poverty" (ABRANCHES, 1986, p. 84).

The Nutrition in Health Program (PNS), starting in 1975, suggested the distribution of basic food—rice, sugar, beans, corn meal, manioc meal and powder milk—to pregnant and breast-feeding women and to children between six months and seven years of age of low income families, giving priority to the poorer regions and providing for 45% of the daily needs (SILVA, 1995) of these people.

As from the beginning of 1985 PNS was renamed Supplementary Nutrition Program (PSA) and intended to reach pregnant and breast-feeding women and children under four years of age. According to Silva (1995) the goal of the government for 1986 was to include 12 million beneficiaries in the whole Brazilian territory, distributing 720.000 tons of food, as well as being better integrated with health actions, aiming at reducing 40% of the infant mortality before 1990.

The foodstuff contained in the PSA minimal food requirement (cesta básica) was chosen based on a former inquiry of food consumption conducted by ENDEF/FIBGE in 1975. This inquiry observed that the foodstuff responsible for 80% of the low income population food consumption was comprised of rice, beans, manioc meal, corn meal, milk and sugar. The minimal food requirement (Cesta Básica) was composed of rice, beans, milk and sugar in all regions. In the Northeast region was included manioc meal and in the Southeast, Middle-West and South regions was include corn meal (DINIZ, 1988). The decline of PSA began in 1987 and gave place to the program called Milk is Health (SILVA, 1995).

Under José Sarney’s government, three programs gained evidence in the nutrition area.

a. The Supplementary Nutrition Program (PSA) implemented by the National Program on Food and Nutrition (PRONAN);

b. The National Program on Milk for Poor Children (PNLCC), implemented by the Communitary Action Secretariat (SEAC) of the Presidency of the Republic; and

c. The National Program for School Nutrition (PNAE) implemented by the Student Welfare Foundation (FAE).

In the first two years of the New Republic the state intervention in the food and nutrition areas was, again, a political priority. Thus, in 1985, were launched three specific instruments of social policies in the area: the subventioned plan for immediate action against hunger and unemployment; the social priorities for 1985 and the social priorities for 1986.

However, as reminded by Vasconcelos (2005), between 1987 and 1989, as a result of Cruzado, Bresser and Verão (Summer) Plans, the economy noticed again a technical, financial and political depletion on food and nutritional programs.

By the end of the 1980's five food and nutritional programs were still under way: the National Program on School Nutrition (PNAE); the Supplementary Nutrition Program (PSA), the Complementary Nutrition Program (PCA); the National Program on Milk for Poor Children (PNLCC) and the Worker's Nutrition Program (PAT). Besides these, there were still the complementation and support programs coordinated by INAN.

1986 was the year of political, economic and social changes in Brazil, including in respect to the public health area. The first changes came with the results of the VIII National Conference on Health, of March 1986, in Brasilia, which was an initiative of the Ministry of Health.

At this event, more than four thousand representatives of all segments of the civil society discussed a new health model for Brazil, including the new health frame as a right of the citizens, which was later confirmed by the Constitution of 1988. This was the

event that synthetised the movement called Brazilian Sanitation Reform born during the fight against the dictatorship and whose motif was Health and Democracy. It was organized in the universities, in union movements and in regional experiences of services organizations (AROUCA, 1998).

The VIII Conference is considered a political boundary for the movement for the democratization of health, due to the efforts made for the social movements to raise the questions regarding health topics.

By the end of the debates, a concensus was reached on the need to formulate a new health policy to contribute for and to reach a progress in the fight for the transformation of the system. This happened with the creation of a single health system based on the universalization, integrality and descentralization principles, under the coordination of the State, although by means of social participation (RODRIGUES, 1995).

One of the best deeds of the VII National Conference on Health was to indorse the creation of the Single Health System. According to Rodrigues (1995), the agenda for the Sanitary Reform Movement was built on descentralization, universalization and equity principles of right to health in the scope of the public system. The agenda for the creation of a Single Health System was a demand based on the critics to the health policies management model of the 1970s, such as: the crisis of the health system inefficacy, inefficiency, iniquity and credibility crisis due to the demographic-epidemiologic transition (outdated and changed nosologic patterns, medication, technological development and boom of costs and expenses [Buss, 2005]).

It aimed also at centralizing governmental policies for the sector disconnected from the Social Security; regionalizing the management of services rendering; giving a privilege to the public sector and to universalizing the service. By the other hand, a wider health concept was being confirmed, as a result of social, political and economic determinants.

Thus, for the State boards, with the participation of State and civil society actors, interested in proposing changes in the public health area, the VIII National Conference on Health meant a limit to the political health history in Brazil and represented the opportunity to suggest criterias to reformulate the National Health System together with the National Constituent Assembly. This Conference had as central topic:

a. health as an inborn right of citizens;
b. reformulation of the National Health System according to the universalization, participation and descentralization principles;
c. organic-institutional integration;
d. redefinition of institutional roles of the political units (Union, states, territories and municipalities) for rendering health services;
e. financing of the health sector.

After the end of the conference was created the National Commission on Sanitary Reform clearly aiming at analysing the difficulties identified in the work of the national network on health services. It suggested options for the new organizational structure of the system by examining the articulation instruments between government sectors acting in the health area and proposing its improvement, indicating mechanisms for pluriannual planning in the sector and adjusting them to the exact needs of the population segment to be served.

In this scenerio of ideas, values, corruption, conflicts and interests that, by means of the correlation of contradictory social forces, in a democratic transition environment, the National Constituent Assembly of 1988 is promulgated. The approval of the new Brazilian Federal Constitution meant a democratic progress in the legal, political and institutional reorganization of the country. The State, in the constitutional context, is then called a Legal Democratic State, founded on: Sovereignty, citizenship, the dignity of the human person, the social values of the labour and the free enterprise and political pluralism (CF, 1997, Art. 1°). Social rights of the citizens are introduced in the 6th article

of the Federal Constitution of 1988. These rights refer to social policies, such as: health, nutrition, education, work, leisure, security, social security, protection of motherhood and childhood, assistance to the destitute.

In the scope of the social policies, the main acchievements with the Constitution of 1988 was the inclusion of the Social Welfare, comprised by the tripod health, social security and social assistance, which became a right of the citiziens. It is not a “controlled citizenship” as in the previous periods, in which citizens were only those with a professional occupation recognized by law (Santos, 1979).

Under the Federal Constitution the Social Welfare shall be organized according to the following objectives: Universality of coverage and service; uniformity and equivalence of benefits and services to urban and rural populations; selectivity and distributivity in the provision of benefits and services; irreducibility of the values of the benefits; equitable participation in funding; diversity of the financing basis; democratic and descentralized character of the administrative management, with the participation of the community, particularly of workers, businessmen and retired persons. (CF, 1997, art. 194, single paragraph).

The descentralization principle overcomes the conception and implementation of social policies. Thus, a new federative pact begins, in which the Federal Government is responsible for the coordination of social policies, and states and municipalities are in charge of their execution. The participation of the civil society would be the main point in this process, as well as the democratic control over State actions in the social policies. According to Pereira (1998, pp. 121-122), the accomplishment of this political-administrative descentralization in the execution of the social policies must, effectively allow for:

a. “the establishment of new participation practices;”

b. “the combination of representative democratic mechanisms (through political parties, unions, etc.), with participative democratic mechanisms (through councils, commissions, etc.), essencial to reach the public space desired".

Thus, were established the paritary boards, social policies management and control instruments, such as the Child and Adolescent Rights Boards, the Tutelar Boards, the National Board on Social Assistance, the Health Board in all governmental levels, among others.

The principles of the VIII Health Conference were incorporated in the Federal Constitution of 1988, based on which was created the Single Health System (SUS) regulated by the Organic Law on Health (LOS), Law 8080/1990. The Intersectorial Commission on Food and Nutrition (CIAN) of the National Health Board (CNS) is also created, with the aim of planning and implementating the Food Security Policy (PSA) an initiative of the Ministry of Planning.

6. Analysis of the PNAN Formulation Process: Contexts, Ideas, Interests, Institutions and Political Instruments

6.1 Political, Economic and Social Contexts of the PNAN Formulation Process (1990–1999)

Various decades of research on the factors that influenced health along the years, made the politicians recognize as determinants the different factors outside the health area, such as: genetic composition, socio-demographic situation, cultural beliefs, environmental conditions, geographic and economic conditions in general.

Solid researches on the determinant factors of health influenced the prevailing argument on public health policies. For example, the public health policy formulators are paying more attention to the formulation processes for the development of policies that consider the issues of vulnerable or marginalized groups with significant and complex health problems related to different determinant factors.

Environmental factors such as emerging technologies and changes in the demographic structure of the population may also increase the awareness of the public, the politicians and the policy makers on public health issues. These factors are motivating a gradual reconsideration of the implications of an aging society on the resources available. Since people are having a longer and healthier life, the pressupositions on the nature and scope of public health programs and services necessary to meet the demands of the society in the health area are being contested.

These external factors and many others had an impact on how the problems related to public health policies are understood. These factors also impact the combination of policy formulation instruments that policy makers bevieve are adequate to deal with such problems (WELLER, G.R, 1980); ANGUS, D. et al., 1995, EVANS, R.G. E STODDART, G.L 1994).

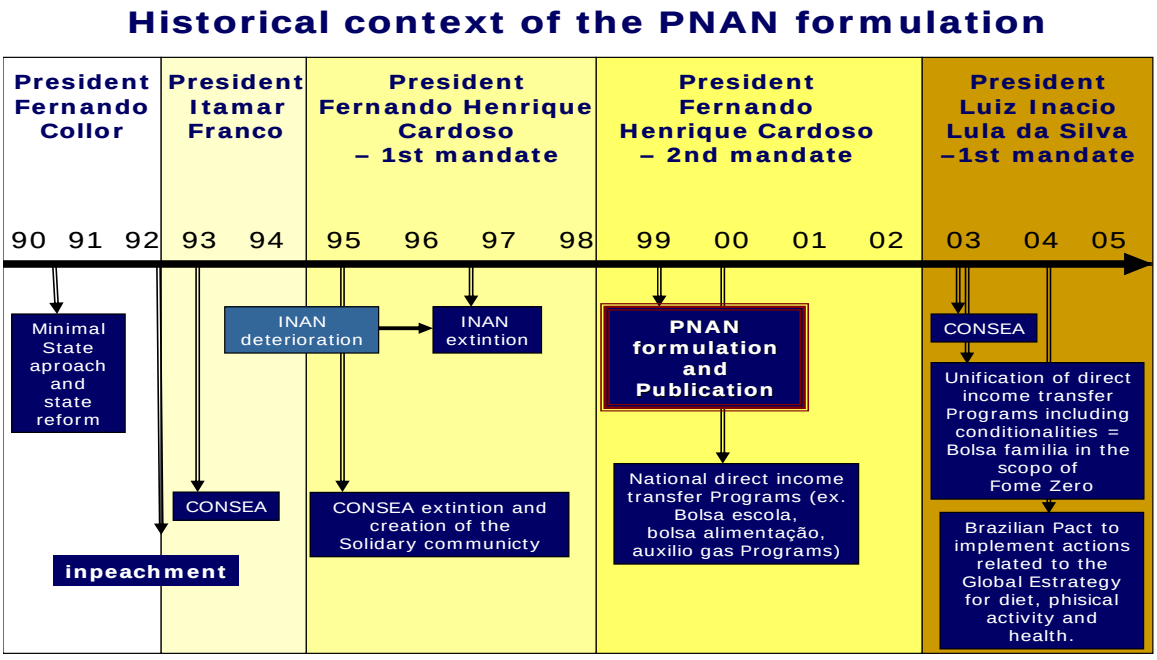
In the Brazilian case, in 1989, the Ministry of Health organized the National Research on Health and Nutrition (PNSN) and demonstrated a decline in the infant malnutrition in comparison to the National Study of Familiar Expenses (ENDEF) from the 1970's. In spite of these results, differences were observed among the Brazilian regions, being the North and Northeast regions the most impacted by infant malnutrition. Based on this work and the physical evidence of malnutrition presented to society at that moment, a huge movement was organized to motivate the formulation of a national policy for this sector.

Frey (2000) argues that one of the most important components of public policy analysis refers to the "political cycle", due to the temporal characteristic of the sectorial policies, as is the PNAN case.

The Brazilian State actions in the food and nutrition areas have been modified as to their conception and management, and their formulation and implementation processes, especially after the 1990's.

As will be observed with the analysis of the 1999-2005 period, the different phases of formulation and implementation of PNAN action strategies, in the period considered, reveal an “investigative model very interesting to study the life of a public policy” (FREY, 2000, p.226).

As deduced by the author, the various phases correspond to a sequence of elements of the political-administrative process and may be investigated in regards of the power scopes, political and social networks and political-administrative practices tipically observed in each context, as follows:



6.1.1 The Collor Government, State Reform and Food and Nutrition Programs

In 1990, year that changed the history of Brazil, was democratically elected the first president after the dictatorship (established since 1964). It was a contradiction that, in that government, the more the country moved forward in the consolidation of democracy, the more it moved in the direction of the implementation of neo-liberal ideas of State reform. Speeches on economic stabilization and State and economy

modernization were combined with the reduction of financial resources, depletion of social programs and extinction of public agencies (VASCONCELOS, 2005).

Fernando Collor de Mello was elected under a strong influence of the mass communication media. An inflation of more than 80% a month was wasting people's money. It was necessary to stop this evil. Protected by the naivety of the Brazilian people and with the unquestioned support of reknown economists, Collor was the greatest advocate of the "neo-liberalism", announcing privatizations and dismissals of public servants all over Brazil. As from that point, many difficulties had to be faced to get to the real democracy. National maturity was still far away. The economic plan announced confiscated savings accounts, current accounts and financial investments.

In 1991, the return of inflation was merciless, and was attacked with high interest rates and consequently, with recession, cooling off of the economy and unemployment.

In 1992, the press denounced a huge corruption in the government. The civil society got organized and formulated a "Manifest for Ethics in Politics" which obtained support in all states of the Federation. Brazilian youths created the movement called "painted faces", and entered the political scene. Indignation was the overall feeling of the country.

The Brazilian Lawyers Order (OAB) promoted a historical walk on September 1st, 1992 in the direction of the National Congress bringing a petition for impeachment of the President. This petition was supported by more overwhelming denounces transmitted by the national media.

The President counter attacked. He called people to go to the streets. On 16 September 1992, people went to the streets carrying manifestation plates, using horns, making protest parades and using black clothes to demonstrate against the insubordinations of the Executive Power and the National Congress.

On September 29th of the same year, began the impeachment process of the President of the Republic, who was immediately removed from his seat. Itamar Franco, the Vice-President assumed the government. The process lasted three months. On December 29, 1992, during his judgement in the Federal Senate, Collor rennouced and had his political rights abrogate for eight years.

Food and nutrition areas were also included in the reforms performed in the Collor period. As Valente observes (2001), this government reorganized the political agencies and instruments concerned with health and nutrition, extinguishing food suplementation programs designed at serving children below five year of age and reducing other programs, such as the National Program on School Nutrition, the Workers' Nutrition Program and the National Institute for Food and Nutrition.

Still according to Valente (2001), the only positive aspect of that period was the initiative to use public food stocks for nutritional programs, a former reivindication of technicians aiming at reducing stocks losses. This resulted in the creation of the basic baskets of food distribution to the population suffering with drought in the Northeast region in 1990. In March of the same year, a representative of the Brazilian Association of the Nutrition Industry (ABIN) was nominated President of INAN and prioritized the substitution of the traditional basic foodstuff by industrialized products.

A key-informant reminds us that the majority of the official documents of this period, 1990 to 1992 and from previous administrations were destroyed. Such documents included food supply, food and nutrition programs and also those directed at the vulnerable group of children under fiver years of age. Other programs were gradually suspended and left inactive, as was the case of the National Program on School Nutrition.

An incoherence of the Collor government was the ratification of the International Convention on Childrens Rights while these social programs were being made ineffective in the 1990s. In the Pluriannual Plan (1992–1995) children and adolescents

were among the priorities of the Government. Nevertheless, what was seen, in practice, was a complete depletion of social programs, especially those directed at mother and infant groups. Food and nutrition programs in previous years represented ways of reducing hunger and malnutrition, especially among children and pregnant women. However, these programs were progressively depleted since the financial resources allocated were much beneath the needs to face the targets announced.

PSA was aimed at pregnant women, breast-feeding women and children with less than 36 months of age coming from families with a monthly income of less than two minimum wages. PSA target was to distribute 378 thousand tons/year to 6.7 million beneficiaries, however, it distributed only 60.401 and 36.484 tons of foodstuff in 1990 and 1991, respectively.

The Nutritional Support Plan (PAN) intended for pregnant women, breast-feeding women and children between 6 and 36 months of age suffered a reduction of coverage of 45% if compared to 1978.

The National Program of the Milk for Poor Children aimed at families with children up to seven years of age and under the auspicies of the Ministry of Social Actions was made ineffective in 1991.

Still according to Escoda, Vilar and Begin (1992), associated to the depletion of programs and the reduction of resources invested in the area, these programs never debated the reversibility of the social hunger and malnutrition. Along the time, they had a very low populational coverage and a low nutritional impact, producing a regional and social inequality. These programs had a better coverage in the most developed regions (South and Southeast) to the disadvantage of the poorer regions (North and Northest). Besides that, the immediate and palliative responses of these programs were aimed at

legitimating the state/government, especially in electoral or intense social movement periods.

The following diagram illustrates the components of the National Program on Food and Nutrition in force during the Collor government from 1999 to 1992 (cf. SILVA, 1995).

Chart 1:
PRONAN Components Preserved in the 1990–1992 Period

Program	Results	1990	1991	1992
PNAE (1)	Population served	29,680,968	29,065,000	30,600m000
	Foodstuff distributed(tons)	138,116	134,685	92,918
PSA	Population served	6,667,000	6,667,000	2,786,000
	Foodstuff distributed(tons)	60,401	36,484	2,899 (2)
PCA	Population served	1,078,000	-	-
	Foodstuff distributed(tons)	11,398 (3)	-	-
PNLCC	Population served	7,818,000	-	-
	Foodstuff distributed(tons)	1,157,316	-	-
PAT	Population served	6,431,693	6,822,917	7,847,413
	Companies participating	33,999	37,751	42,213
PNIAM				
Preventing Anemia and Hypovit. A	Almost completely interrupted.			
PCBE	Reduction in the acquisition of potassium iodate; suspended inquiries in the *sentinel areas.*			
(1) Includes PAIE which, in 1990, received 17.8% of the foodstuff distributed; (2) Powder milk with resources of the extinct PNLCC; (3) Besides the 1.6 million basic baskets acquired in the last month of the year.				

6.1.2 Consolidating Democracy: Political Participation and the National Council on Food Security (CONSEA) 1993–1994

After the impeachment of Fernando Collor, initiatives of the civil society motivated the establishment of CONSEA on 24 April 1993, by Decree No. 807, during Itamar

Franco's government. This council was composed by one third of government members and two thirds of civil society members.

Among so many events, between 1990 and 1992, motivated by the government insubordinations, by the lack of social policies and, consequently by the increase of poverty and hunger disseminated in the country at that moment took place a fight for the right to citizenship. This culminated in the Movement for Ethics in Politics and the Citizenship Action against Hunger and Poverty and for Life.

In the Itamar Franco's government (1993–1994) was created the National Council for Food Security (CONSEA). The proposal had been suggested to the Collor government, who was not moved. In February 1993 it was presented again to the new president, Itamar Franco, and subsidised the establishment of the National Plan to Combat Hunger and Poverty, as well as the creation of the CONSEA in May of the same year. It was the first effective partnership between the civil society, by means of the movement lead by Hebert de Souza, the so called Betinho, and named *Citizenship Action against Hunger and Poverty and For Life,* and the public power, which allowed for the begin of a remarkable phase of mobilization in the country. As from this moment, the confrontation of hunger and poverty became an issue discussed in the scope of the economic and social policy and the food and nutritional policy, with a continuous debate between the civil society and the Government. CONSEA proposes the Emergency Food Distribution Program (PRODEA) as a response to the Hunger Map, divulged by IPEA in 1993. (LAGE, 2006)

Between 1990 and 1992, the fight for citizenship having as main actors the Movement for Ethics in Politics and the Citizenship Action against Hunger and Poverty and for Life establishes solidarity and urgency actions in the whole country. However, the filanthropic characteristic of food donation was the main, if not the only, reaction to the hunger and poverty problem and the solidarity characteristic (as the participation and valorization of social movements) was reduced to the assistencial and voluntary model, dissociated from the critics on the social production of the hunger problem.

Through Betinho's engaged militance the discussion on the actions for citizenship against hunger and poverty were increased. It cooperated to strengthen the thoughts within several social sectors on the emergency for an agrarian reform and the reorientation of food supply policies.

In spite of the short experience in the 1993–1994 period, CONSEA raised the discussion about hunger and the consideration on food security in the official organisms. In this period, food and nutrition issues, although having only few programs and institutions, worked for the rationalization sought at the end of the 1980's.

The objectives of CONSEA were:

a. to establish the guidelines of the Plan to Fight Hunger and Poverty;
b. to conceive the adequate strategy for its implementation;
c. to mobilize the resources necessary to meet these objectives;
d. to motivate the partnership and integration between public and private, national and international organisms, with a view to guarantee the mobilization and rationalization of the use of resources, as well as the supplementary characteristic of the actions developed;
e. to coordinate the awareness of the public opinion to combat hunger and poverty, aiming at joining the governmental and society efforts;
f. to inspire and support the creation of state and municipal committees to combat hunger and poverty (Crusius *et al*., 1993 *apud* Pereira, 1997, p. 104).

CONSEA proposed the Emergency Food Distribution Program (PRODEA) as a reaction to the empirical evidences on the Hunger Map (IPEA, 1993) as well as by the appeal of the social action for citizenship for the emergencial distribution of food. However, even though the practice of basic baskets distribution was not recent in the country, during that time it received many critics from the public opinion, especially due to its assistencialist character, which was disconnected from the determining factors of

economic, social, political and cultural inequalities that create poverty, privation and hunger in the country.

By initiative of the CONSEA, in July 1994 was organized the I National Conference on Nutritional Food Security (I CNSAN). The “political community” that participated of the I CNSAN consolidated the concept of food security as a guarantee for overall access to food with good nutritional quality.

This first conference resulted from a national social mobilization process around the “nutritional issue” and from the awareness on the aggravation of hunger in Brazil. It produced also a political declaration and a programatic document with the conditions and requirements for a National Policy on Food and Nutritional Security (Maluf, Menezes & Valente; 1996).

The main results produced by the I CNSAN were:

a. to increase the conditions of access to food and to reduce its participation in the family budget;
b. to guarantee health, nutrition and food to specific populational groups (in nutritional or social risk);
c. to guarantee the biologic, sanitary, nutritional and technological quality of the foodstuff and its utilization;
d. to encourage feeding practices and a healthy life style.

6.1.3 From the Food Security Council (CONSEA) to the Solidary Community (1995–2002)

In 1995, Fernando Henrique Cardoso assumed the office of President of the Republic. One of his first political measures in the social policy area was the extinction of CONSEA and its replacement by the Solidary Community Program, focusing on the combat to hunger in the municipalities.

The Solidary Community Program (PCS) was ruled by Federal Decree No. 1.366 of 12 January 1995, with the aim of “coordinating the governmental actions to serve the portion of the population without resources to provide for their basic needs, and especially to combat hunger and poverty” (Silva et al., 2001, P. 72).

PCS represented a federal government strategy to join civil society and State actions in all govenrmental scopes (federal, state and municipal), as well as the integration of federal initiatives in municipalities with a greater concentration of poverty in Brazil, at that time.

Idealized as an alternative to reformulate the institutional project of the Plan to Combat Hunger and Poverty and for Life (PCFM) from the Itamar Franco government, which was coordinated by the National Council on Food Security (CONSEA), PCS should “confer a greater efficacy and efficiency to governmental actions, without greater pressures in the public expenses. It was a proposal to coordinate programs already developed by different Ministries" (Silva et al. 2001, p.74).

The priority areas for the implementation of PCF actions were:

a. reduction of infant mortality;
b. food;
c. support to basic schooling;
d. urban development;

e. creation of employment and income;
f. professional qualification.

Many critics were done to the assistentialist character that prevailed in the actions of the Solidary Community Program, as a strategy to face poverty at that time.

The first refers to the disconnection of these actions from the structural distortions present in the Brazilian society (CAMPOS, 1995, apud SILVA et al. 2001, p. 76).

The second argument focuses in PCS as a federal government strategy, transfering the reponsibility of social policies to the civil society. Solidarity was used as a justificative, and was represented by fragmented, selective and focused actions (QUEIROZ & MATSUBARA, 1995, APUD silva et al. 2001, pp. 76-77).

The third critic refers to the neoliberal aspect of the Program, according to Sposati arguments (1995, mentioned by Silva et al. 2001, p. 77), among which we emphasize:

a. extinction of social assistance agencies, transfering the public responsibility for social policies;
b. emphasis on the centralization of the federal executive, even under the discourse of the descentralization of actions in states and municipalities;
c. indefinition of the resources, which depended on different Ministries and were assigned to different programs, confering them an instable characteristic;
d. focused and selective actions;
e. return of paternalist and patrimonial practices.

In 1996, the international situation was extremelly favorable to the food and nutrition area. In that year the United Nations Food and Agriculture Organization (FAO) organized in Rom the World Food Convention. This conference placed in the international and national public agendas the focus on food as a human right. In this Convention were

divulged other information to show that the issues regarding nutrition were concealed in politics and they needed to be recovered in order to obtain an institutional reaction.

With the opportunity raised at the World Food Conference, the discussion on the need to formulate a National Policy on Food and Nutrition gained strength, especially, with the mobilization of a small group of technicians of the former INAN, extinct in 1997, which inserts this issue in the sectorial agenda of the Ministry of Health.

The discussions were encouraging and strenghtening the group of technicians, and the concepts and need to work the intersectorial characteristic of the issue, mainly, with a view to face the infant mortality and malnutrition aspects in Brazil.

However, with the extinction of INAN, the policy formulation course was interrupted—while was being sought the inclusion of this policy in the Ministry of Health,—in the beginning of the 1990s when almost all food and nutritional programs were extinct by the government.

Impelled by the international organizations that worked with food and nutrition issues with an approach directed at food and nutrition security, INAN—suffering with the insubordination and corruption—was facing inexpressive discussions about the uncommon progress of chronic diseases. Such discussions were also present in the Ministry of Health, more specifically in the diabetes and hypertension coordination in which some indicators of researchs done in Brazil were being considered. These were not enough to translate in actions the confrontation of this issue.

For Valente (2002), in the perspective of the FHC government, the confrontation of the food and nutritional security issue disappeared from the political agenda, even with the continuation of some actions within the scope of the Solidary Community Executive Secretariat in a partnership with the civil society involved in the fight for Food and Nutritional Security. Among these actions are: a) the effort to build and monitor the Food Security budget; b) the preparation for the World Food Summit, which begun by the end of 1995 and was concluded in June 1996; c) the effort to maintain the compliance with

the resolutions of the World Food Summit (Rome, 1996) at national level; d) the organization of a Data Bank on Food Security in a partnership with IPEA.

The priority given by the FHC government to food security may be, at some extent, measured by the efforts above mentioned. Among them is the elaboration of the Brazilian document for the World Food Summit (1996). In this process, the public debate on Food Security was recovered and the Human Right to Food was included in the document as one of the commitments of the Brazilian society to this issue. The debate process also made clear the disparities between the proposals of the government economic area and those of the social sectors involved.

The work of the Executive Secretariat of the Solidary Community Program—also according to Valente (2002)—was progressively set apart from the civil society. However, it is important to recognize that it was transformed in an interesting instrument to coordinate the governmental social action. Eventhough it did not have power to interfere in the management of policies in the economic area or even in the widest definitions of the social policies.

Its application aimed at fighting hunger, poverty and social exclusion in Brazil, by improving the efficiency and efficacy of social programs meant for the poorest groups of the Brazilian population (IPEA, 1998). The Secretariat acted based on the principles of solidarity, descentralization, partnership and focus and convergence of actions. The work was centralized in the poorest municipalities of the country, and 20 programs from nine Ministries were chosen to build the basic agenda. The proposal established that these municipalities would receive a priority stamp to encourage the differentiated allocation of resources to them.

One of the most complex duties assumed by the Executive Secretariat of the Solidary Community Program was to coordinate the Food Distribution Program (PRODEA), which begun in 1995. This program, created in an emergencial basis, was

later transformed in a permanent social program, due to the absence of structural actions and social policies that could replace it (Valente, 2002).

In the second mandate of President Fernando Henrique Cardoso, in the beginning of 1998, were introduced some changes in the Solidary Community Program, with the implementation in January of 1999, of the Sustainable Integrated Local Development Plan, called Active Community. This became the main strategy of the Secretariat to combat poverty and, since the beginning, manifested the intention of not working with hunger, malnutrition and food security issues. As a consequence, PRODEA was extinct by the end of the year 2000.

During this period, one of the few governmental areas to keep a discussion on food and nutrition, within a food security perspective, was the Technical Area on Food and Nutrition (ATAN), which had been recently created at the Ministry of Health.

In 1999, after a deep discussion with civil society, the National Health Council approved the new National Policy on Health and Nutrition which was settled within the perspective of promotion of Human Right to Food and indicateds the need to build a wide policy on Food and Nutrition Security.

As a way to institute PNAN, the Technical Area on Food and Nutrition of the Ministry of Health received political support from the sector and the government to implement the Food Basket Program. This program would in a certain way replace PRODEA in what regards its nutritional dimension directed at children and pregnant women from poor families.

Thus, the two last years of the FHC government were marked by the absence of an organized social policy due to the pulverization and fragmentation of initiatives in the sectorial areas of Health, Education, Agriculture and Supply and, Work and Planning, It contributed for building a Basic Agenda implemented by municipalities by means of agreements settled with the respective Ministries, according to the following chart:

Chart 2:

Programs of the Solidary Community Basic Agenda Distributed by Area of Actuation and by Ministry Responsible

Area	Program	Ministry
1. Reduction of Infant mortality	a) Program to Fight Infant Malnutrition b) Mother-Infant Coordination c) National Immunization Program d) Health Communitary Agents Program (PACS) e) Basic Sanitation Actions	Ministry of Health
2. Food	National Program for School Nutrition (PNAE) Emergency Food Distribution Program (PRODEA)	Ministry of Education, Ministry for Agriculture, Livestock and Supply
3. Support to basic study	a) Basic School Material Scholarship / Basic Basket (student, teacher, school) b) Student Health Program c) National Program on Transport for Students d) Child Education Program	Ministry of Education
4. Support to Family Farming	National Program to Strengthen Familiar Agriculture (PRONAF)	Ministry for Agriculture, Livestock and Supply
5. Creation of Employment and Remuneration; Professional Qualification	a) Program for the Creation of Employment and Income (PROGER) b) National Program for Professional Education (PLANFOR) c) Program for Professional Qualification - Employment Mediation	Ministry of Labor
6. Urban Development	a) Housing Program - Brazil b) Social Action and Sanitation Program (PASS)	Ministry of Planning and Budget

Source: Silva et al. (2001, pp.143-144).

Within this context, the Food and Nutrition Security issue did not have a partner in the government. The initiatives to articulate around a food and nutritional security policy were completely spread.

6.1.4 Restoring Food and Nutrition Security as a Government Priority (2003–2005)

When Luiz Inácio Lula da Silva assumed the Presidency in January 2003 he placed the fight against hunger and poverty within the governmental public agenda. It was an absolute priority of his mandate. Therefore, still in 2003 he launched the Program called “Hunger Zero” as the main strategy of his government, which was expressed in the Pluriannual Development Plan (PPA) 2004–2007.

The objective of Hunger Zero Program was to fight the structural causes of hunger and poverty, as well as to guarantee there would be *food in the tables of those who most need it*. Therefore, this Program propagates the idea that citizens have the right to food of quality.

The Program proposes the eradication of hunger for 44 million people with income of less than a dolar a day and therefore, should count with the intensification of structural policies: creation of workplaces and increase of income, intensification of the agrarian reform; universal social security; family scholarship, minimum income and incentive to family farming. The Program includes also complementary policies, such as: Food Card; expansion and re-orientation of the Worker’s Food Program; donation of emergency basic baskets, management of the mother-infant malnutrition; maintainance of the security stocks; increase of school lunch programs, guarantee of food security and quality, creation of programs for education on nutrition and education for consume and several other local policies.

In the social protection area the government decided to unify all programs of income transference of the previous government, such as gas allowance, school scholarship, food basket, among others. They were included in a single program called Family Scholarship, under the orientation of the so called Special Minister for Food Security which is now the Ministry of Social Development and Hunger Combat (MDS). The Familiy Allowance Program was conceived based on critics made to the Hunger Zero Program and exposed the power of governmental reaction trying to rebuild the link

lost with social policy. Within this logic, while Hunger Zero Program was a State action that mobilized society, the Family Scholarship, as a governmental program, promoted the search for a rational application of the public resources in the social area (NÉRI, 2005).

Hunger Zero Program actions should involve several sectors, such as: Agriculture, Health, Education and Planning and the society. Food and nutrition actions developed in the scope of the Ministry of Health are based in the National Policy on Food and Nutrition. The responsibility for the implementation of this policy belongs to the General Coordination of the Food and Nutrition Policy (CGPAN) at that time linked to the Health Policies Secretariat, now called Health Service Secretariat (SAS), within the structure of the Ministry of Health. The democratic control is given to the Intersectorial Commission on Food and Nutrition (CIAN) of the National Health Council (CNS).

With the institution of the Global Strategy for Healthy Feeding and Physical Activity proposed by international organizations, PAHO, WHO and FAO and ratified by the Brazilian government in 2004 important and decisive actions take place within the Ministry of Health. This aimed at dealing with the food and nutrition issue, even in a fragmented and conceptually scattered way.

Still in 2004, with the return of CONSEA as the mainspring of the Hunger Zero Program, took place in Olinda (PE) the II National Conference on Nutritional Food Security (II CNSAN), ten years after the first CNSAN.

The deliberations of the II CNSAN comprised proposals of strategic actions for a national policy on food and nutritional security and 19 motions on various issues regarding Nutritional Food Security in Brazil and in the world.

The debates within the thematic groups and plenaries as well as the propositions approved reaffirmed the main principles that must be associated to food and nutritional security and be considered in the actions and public policies aiming at promoting them.

They are: a) to adopt the promotion of human right to healthy food, placing food and nutritional security as strategic and permanent objectives associated to the sovereignty on foodstuff; b) to assure the universal access to food of quality, especially by means of the creation of employment and income and observing educational actions; c) to seek an interconnection of the actions by means of the intersectorial joint plans and with social participation; d) to respect the equity of gender and ethnics, recognizing their diversity and valuing their nutritional cultures; e) to promote familiar farming based on agroecology, together with the sustainable use of natural resources and the protection of the environment; f) to recognize water as a basic nutrient and a public property.

These principles ordain the national policy on food and nutritional security. Thus, they are references that confer sense and organization to the 153 proposals of strategic actions approved by the II CNSAN, of which 47 were defined as priority. (CONSEA; 2004)

6.2 Ideas

The ideas represent information that the policy makers use to recognize a public health problem and to decide on the best way to behave. Personal values are an important source of information for politicians to formulate public policies.

In the health promotion area, recent researches in Canada and the United States suggest that personal convictions of policy makers about the governmental role to promote healthy behaviors are a significant factor to influence their support to the legislation on tobbaco control, especially in the policies to promote health. We know also that the debates on various issues on health promotion/prevention of diseases are related to values regarding personal choices and not to public security (COHEN, J.E. et al, 2002).

Public policies are also formulated based on empirical evidences produced by researchers from public or private universities and from research institutes. Each of

these centers that produce researches is influenced by its own group of values to gather and analyse information. For example, there are research institutes with leftist political tendencies that present a given perspective on the issue and institutes with rightist political tendencies that have another perspective. The information from these institutes may be used by governments in different provinces, according to the most adequate ideology at a given moment.

The third source of information for policy makers are the conversations held with the general public or representatives of different interest groups. Although informal and not scientific, this source of information is considered extremely important to influence the arguments of policy makers.

A fourth source of information is the research on the public opinion. Governments are using more and more this kind or survey to obtain information on the preferences of the general population regarding the main political issues. This kind of research is the most scientific way to determine the opinion of the citizens if compared to the results of personal meetings and informal conversations. Some people affirm that public opinion researches became the most important source of information for those responsible for political decisions.

The majority of the information described above is depurated by the popular communication means, including newspapers, magazines, radio and television until they get to the knowledge of those responsible for the decisions and to the general public. The way an issue is addressed by the popular media may have a great impact on the public opinion and on the choices the policy makers may take when formulating a specific issue. If the media does not recognize the existence of an issue, the government may not feel compelled to do something about it.

At a given moment, certain generalized ideas on public policies will be widely shared and will be the basis for the discussion of policies. This may coincide with a basic and ample consensus of the population on a national issue (national order). But, the

ideas supported by policy makers and the general public, nowadays, may be abandoned some time in the future. Therefore, the ideas on policies may reach the discussion point depending on the circumstances. After reaching this point the policy makers either transform the ideas in policies or reject them. Lastly, the way problems regarding policies are defined and the values that receive a preferential treatment are considered factors they have a great influence on the solutions considered and chosen.

Ideas and values go beyond the elaboration of public policies. This occurs because the public policies define not only the governmental discourse, but also the governmental action. A public policy may also be defined by the group of decisions taken to respond to a given social problem. After all, as political beings, we are taking decisions all the time: “to decide that there is a problem; to decide that it is necessary to try to solve this problem; to decide on the best way to solve the problems; to decide to legislate on the subject” (Subirats, 1994, p.41). In order to understand public policies it is necessary to consider them as a process that contemplates a flow of interaction between the actors involved in the elaboration, implementation and evaluation of public policies. The decisions imply, on the other hand, that judgements of values, ideas, interests and conflicts are processed in an institutional scope.

To understand the processes of public policy formulation, we need to understand the characteristics of the actors: which institutions they represent, which roles they play, which authorities they represent or have, how they behave and control each other (Lindblom, 1991, p. 11) and, above all, which interests, ideas and institutions they defend. We know the actors involved and interested in the process of public policy formulation do not agree completely on the problems, the alternatives of solution and the alternatives chosen.

There are different interpretations of the problems and alternatives. There is a cycle to negotiate, fix and impose the decisions and, finally, different forms, strategies and opportunities to make an issue go forward in the public agenda. It includes the propagation of new ideas and values about the design of public policies.

The democratic and participative process of public policy formulation implies a negotiation among different ideas and points of view that may or may not take to rational agreements, such as the normalization of the National Policy on Food and Nutrition.

Here, we are interested in analysing the cognitive processes of public policies formulation, according to the conception of Yves Surel and Pierre Muller (1998) such as paradigms, ideas and references.

According to the authors, this current of public policies analysis was developed after 1980, as an effort to understand the public policies as cognitive and normative shades building systems that represent the reality within which public and private actors could include their actions. This is, thus, an approach that establishes the importance of the dynamics in the social structure of reality to determine socially legitimate pictures and practices in a certain situation as understoodd by Berger and Luckmann (1986, apud MULLER E SUREL, 1998).

Thus, how could the ideas and values of different actors of the State, the society and the market be included in the text of the National Policy on Food and Nutrition? How could these ideas be formed? Would these be social formulations of the reality on the problems and solutions regarding food and nutrition in Brazil? So, how did this process take place? How could these actors negotiate, fix, persuade, argue about the ideas and values?

PNAN formulation began in the 1970s with the studies and programs performed and/or coordinated by INAN, the organism that was responsible for the actions in the food and nutritional areas, under the management of Bertoldo Cruze Grande de Arruda, as emphasized by a key-informer.

The main national researches that supported PNAN formulation were:

6.2.1 National Study on Familiar Expenses (ENDEF)

Accomplished between 1974 and 1975, ENDEF was a home research, in the national scope (except for rural areas in the North and Middle-West regions). The data collection for this study took a whole year. ENDEF was performed by the Brazilian Institute on Geography and Statistics Foundation (FIBGE) aiming at collecting relevant data on familiar budget and food consumption. Its main focus was the analysis of the nutritional situation based on the family budget scenery. It was already accepted that poverty was the main cause of malnutrition. It was urgent and extremely necessary to know the family budget distribution, the familiar priorities and the percentage of the family income spent with food.

With such a huge sample, about 55 thousand homes and data of approximately 53 thousand families, ENDEF was one of the most complexes (difficult and highly invasive research) and more expensive studies already done in Brazil. The samples design had to be adapted to several analysis needs, such as the supply of substantial information to 22 geographic layers: 9 metropolitan regions / Urban Areas of 7 regions (Rio de Janeiro; São Paulo; macro region South; Minas Gerais+Espírito Santo; macro region Northeast; macro region North; and Mato Grosso+Goiás), Brasília and Rural Areas of 5 regions (Rio de Janeiro; São Paulo; South region; Minas Gerais plus Espírito Santo; and Northeast region).

Another peculiarity of this study was the inclusion of the methodology to weight food, which, in order to viabilize the research and reduce costs, should be done in two houses at the same time. For this procedure to be possible it was necessary to chose in the sample selection a pair of neighbouring houses. This reduced the time for the interviewer to move from one place to another and allowed for data collection in both houses, by a single interviewer each week.

The research methodology applied by ENDEF consisted of making interviews in each house for seven consecutive days. Such a procedure allowed the interviewer to

see the differences of food consumption during a whole week, including the typical weekend variations.

Besides these information on food in the homes, were also collected other socio-economic data, such as family composition (sex, age, migration and relation to the boss for all family members), employment and income. Anthropometric data of the inhabitants were also collected, as well as complementary information such as the presence during meal times and special feeding conditions.

Aiming at calculating the annual food expense of the family, the research extrapolated these data on effectively consumed food to the rest of the year (all 365 days of the year). This adds a special component to this study: the possibility of separating the monetary and non monetary expenses with food. The last one refers to foodstuff obtained by familiar production, hunting, fishing, catching, exchanging, donations received, obtained from the business managed by the family or obtained as payment for services rendered.

6.2.2 National Research on Health and Nutrition / PNSN

It was performed by INAN (National Institute on Food and Nutrition) with the support of IPLAN and IBGE. It was done in a national domicile sample such as PNAD (National Research on Homes Sample) and thus allowed the employment of IBGE supervision and field teams in the research. The sample consisted of 17.920 homes in the whole country.

PNSN sample plan was designed at supplying representative estimates of the Brazilian population residing in private and collective homes. This definition excludes the population living in collective institutional homes and those residing in Indian settlements. For this research were trained 498 field teams that recorded the height and weight of the 62.000 people interviewed. Anthropometry and questionnaire were used aimed at checking the nutritional and conjunctural health conditions of the interviewees.

Information on the various food and nutrition programs were also collected in different population layers, as well as issues regarding breast feeding, sanitation, characteristics of the home, income, occupation and other variables. These data allowed for the interpretation of the nutritional chart seen due to their socio-economic determinants. The research took two and a half months and the field work took place from July 3rd to September 15th, 1989.

The combination of data provided by PNSN allowed the formulation of diagnoses of populational representativeness for the 9 scopes informed by rural and urban areas in the five Brazilian macro regions (excepting the rural North).

Some preliminary data of the research were divulged in March 1990 and contained data of children below 10 years of age. The second report of the research, published in September 1990, comprised aspects related to the growth of the population bewteen 0 and 25 years of age. The third report, from September 1991, analysed the nutritional conditions of adults and elders in Brazil.

6.2.3 Research on Demography and Health (PNDS)

It was performed by BEMFAM (Civil Society Familiar Welfare in Brazil) in 1996 and is part of the world program for the Research on Demography and Health (DHS). It had other two editions, in 1991 in the Northeast region and in 1986 in the whole country. The researches on demography and health work on national/regional representative samples for women between 15 and 49 years of age and are outlined to manage information on fertility, mother-child health and socio-economic characteristics of the population interviewed. In the fertility area, the information collected allowed for the evaluation of fertility levels and tendencies, knowledge and use of contraception methods, breast-feeding and other determinants regarding fertility, such as proportion of married women and/or women living with a partner and duration of post-delivery amenorrhea. It investigated also the reproduction intentions and unsatisfied needs regarding familiar planning.

In the mother-infant health area, the research collected information on the mother mortality ratio, DST/AIDS, pregnancy, prenatal and childbirth assistance. In what regards children health, the data collected allowed for the determination of infant and child mortality rates and tendencies and also the analysis of the socio-economic determinants for this situation. The main causes of the predominant child diseases are investigated (diarrhea and respiratory infections) as well as immunization, nutritional condition, access to water and sewage.

The research focused also on the socio-economic characteristics of the population interviewed, such as: age, education, access to the means of communication, occupation, color, religion, situation of the house in relation to access to water, sewage, electricity, durable comsumer goods, number of rooms and prevailing roof, walls and floor materials.

In the 1996 version of the research, besides the research with the female population a smaller sample of 25% of homes was selected for a research with the male population. This aimed at analysing from the male perspective, information on knowledge, attitudes and practices related to familiar planning, the reproductive intentions and the knowledge and sexual behaviour regarding AIDS.

The research began on September 1995, with the creation of an Integrated Consultive Committee by public and private institutions with a significant actuation in the production, analysis and disclosure of health and demographic data in the country. The participation of the committee contributed to the discussion of the questionnaire content, the scope of the sample, the evaluation of the analysis plan and the disclosure of research results. The research had also the collaboration of IBGE for selection of samples (model PNAD) and the participation of technicians during the field teams training phase and data input.

In what regards ideas and values, the political pressuppositions were included based on the premisses defined and agreed in the document presented by Brazilian authorities at the World Food Summit in Rome 1996. Such document focused on the ideas on nutritional food security. Besides the access to food the new focus proposed they should have a high quality, should respected the cultural and social diversity and be economically and environmentally sustainable. Such a focus aims at preventing problems such as malnutrition, chronic noncommunicable diseases, overweight and obesity.

The need to evaluate and assign the issue in a clear and consensual way forced governmental authorities at that time to viabillize the different currents and ideas, interests and values and transform them in a policy for the sector.

The assignment of these discussions occurred with the creation of a work group, comprised by food and nutritional area professionals, managers of public policies to coordinate the formulation of this policy within the Ministry of Health.

As INAN was extinct in 1997 and the food and nutrition area was being reorganized and reformed within the Ministry of Health—since the "work group nominated to the PNAN formulation was composed by technicians and managers coming from INAN"—the mais actor was the group remaining form INAN. This group had various external supports, through the National Council on Food and Nutrition, with representatives of different ministries and a strong support of universities: "*almost always during the formulation of global or sectorial programs university professionals were invited to participate".*

Besides the actors mentioned, medical institutions, the Federal Nutritionists Council, some international organizations as UNICEF and the World Health Organization also contributed to the ideas and values. These institutions were "*the most relevant actors for the implementation of the National Policy on Food and Nutrition"*, according to the perception of a key-informant.

The establishment of this policy was based on scientific evidences suggesting important issues to the food and nutrition profile in Brazil. There were some multicentric studies data on the evaluation of the Milk Program (PNCC) and issues on the need to create the Food and Nutrition Surveillance System (SISVAN). As stressed by a key-informant, “it was like a patchwork, sewing thematic, conceptual and strategic issues fundamental to see the scope of the policy”.

There was a consensus within the PNAN formulation work group that it was possible to design a policy with a wide point of view but coordinated by the health sector. In an intersectorial context, were included representatives of the Ministries of Agriculture, Education, Agrarian Reform, Planning and Budget, Foreign Relations, Science and Technology and Labor and Employment.

From the Single Health System (SUS) participated the representatives of the main national supervisors, such as the National Council of Health Secretaries (CONASS) and the National Council of Municipal Health Secretaries (CONASEMS). The policy was taken to discussion in the Tripartite Commission scope and, therefore, the considerations of state and municipal supervisors were collected:

It is important to mention the contribution of the National Council of Education due to its paritarian constitution and of the civil society and the government to improve the quality of the Tripartite Commission.

Food industries also participated as representatives of the private sector. They gave essencial contributions to the discussion of breast-feeding and to the production of goods aimed at breast feeding.

Professionals that work as contributors in the local public services supporting and implementing food and nutritional actions in the whole country were also called.

The collaboration centers in the food and nutrition areas in the universities (Federal University of Paraná, Federal University of Goiás, Federal University of Pará, Federal Univesity of Bahia, IMIP and National School on Public Health/FIOCRUZ) contributed to build empiric evidences for the design and formulation of PNAN. It was a technical and scientific support for policy makers. Besides the collaboration centers, participated also Unicamp, the Federal University of Pelotas and the Federal University of Pernambuco.

The work group counted also with the effective participation of the civil society by means of entities such as the Brazilian Soil for Food Security (SBSA), the Brazilian Institute of Social and Economic Analysis (IBASE), the Institute of Higher Education and Research (INESP), the Brazilian Institute of Consumer Defense (IDEC), the Children's Pastoral, the Federal Nutritionists Council (CFN), the Brazilian Association of Nutrition (ASBRAN) and the Association for Education in Corporate Administration. *"All of them participated in different moments of the discussion, sometimes in meetings, sometimes by circulating information through the internet".*

Some strategic international partners such as PAHO and WHO gave physical and finantial support to the workshops.

As emphasized by a key informant,

> We must stress the mobilizing role and the interface work done by Doctor Denise Coitinho who, having participated in various international fora approached the international demands and the issues debated in the formulation of PNAN.

In what regards PNAN cognitive analysis area and its contributions to build a public agenda on prevention, control and surveillance of chronic noncommunicable diseases in Brazil, the interviewees stressed that the actors not only considered infant malnutrition an issue, but also suggested that the obesity issue was linked to inadequate feeding habits and insisted on the debate of nutritional deficiency issues. In fact,

> Brazilian nutritionists and sanitarists are already aware of this and PNAN, which was approved by the Brazilian sanitary authorities in 1999 and confirmed by minister Humberto Costa in 2004, also understands that way.

The guidelines of the policy in the plan of intentions were negotiated and formatted in a basic text. They were agreed in the federal and state scopes and by the civil society, in meetings and discussion seminars, with the participation of market segments interested in the food sector in Brazil.

The actors clearly endorsed the simultaneous combat to chronic energetic deficiencies, most common nutritional deficiencies such as lack of vitamin A, iron-deficiency anemia, goiter, overweigh and dietary imbalances that increase the incidence of chronic diseases such as diabetes, hearth diseases and even some kinds of cancer.

The actors stressed also that in order to reach their objectives many actions proposed by PNAN depended on the agreement and involvement of other governmental spheres other than the Ministry of Health. Examples of typical intersectorial nature actions are: legislation on nutritional labelling of foods, restriction of publicity of unhealthy foods (as well as of alcoholic beverages), regulation on the maximum amount of salt permitted in industrialized food, promotion of a healthy nutrition in schools and work environments, motivation to the production of fruits and vegetables, discrimination of fiscal policies for taxation of more and less healthy foods, urban planning measures that motivate physical activities, informational campaign using the mass media, among others.

Naturally it concerns the fragility of the dialogue and the intersectorial practices of public policies in Brazil, *"especially those unable to guarantee substantial changes between the social agents and their conceptions of well-being, equity principles and rules to evaluate actions."*

The State leaves its public responsibilities which prevents it from acquiring a greater experience about the possibilities of a joint work. The actors engaged in the food

and nutrition defense area, such as public policy—duty of the State and right of the Citizens—believe that,

> in spite of these obstacles and difficulties, the movement can recover the value of the attachment in the discussion on citizenship, taking it from the parish friendships and familiar networks to the solidarity among unfamiliar people, moving it from the basic philanthropy to the discussion of public policies.

Another key-informant says that ideas and values of multiple sectors were not observed in the scope of politics because politics had its limits, as can be confirmed by the following argument:

> The technical area team on nutrition was very small and listened to those people close to it, those who had already worked in the sector, the more active social movements. The poticy reflects, for example, a complete lack of research among indigenous peoples, homeless, obese people and diabetics. If considered the effective level of consultation to these groups, it will be noticed it was very small. It was not only due to the unwillingness, but also due to the lack of effective conditions.

And he still adds that:

> if we consider that it grew in a sectorized way, it was not very efficient due to the whole situation, which was more interested in the consequences than in the determinations, althought they were part of these determinations, even in a very unassertive way. There is a lack of sectors. At that time ANVISA, created by Law 9782/99, was not active as it is today. If ANVISA existed at that time, various actions could have been implemented, such as food labeling.

Within the ideas and values that influenced PNAN formulation, an important characteristic was the extinction of the Food Security Council in 1994 by President Fernando Henrique Cardoso (1994–2002). At that time he created the Solidary Community Program intended at joining governmental programs and actions within the civil society which "*later on was not successful and finished like a philosophic play*".

In the PNAN formulation process, a lot was discussed on the human right to food in what regards food access, but little was said about consumers' rights.

> The consumer must have sound information to choose his food. Taking into consideration that about 70% of Brazilian families live in urban regions, they are consumers and are very far from the food consumption view of the rural experience. We buy food and thus, the policy could also have advanced more.

> In relation to ideas, one of the guidelines translated in the greatest news in the policy technical terms regards the promotion of healthy food.

> Before the nutrition policy, this issue was not very clear in the nutritional area:

> We acted in a very unassertive way in this area because there was still the understanding that the most basic issue was poverty. The problem was of access to food. With access to food everyone would know what to do properly. This was a narrow sight. We thought access would solve everything but it does not. It is not that people do not know what to do, but they are under an environmental influence that does not motivate a healthy choice. If the mother knows what is right but the advertisement in the TV promotes another thing, this is a fight with unequal information. I think this was our mistake when we thought it was all a matter of access. That is not true because environmental aspects that influence the choices independ from the persons will to make better choices. The person may want to make better choices and these may be unapproachable. The person may want it, but the publicity does not help her taking this decision.

Regarding the idea of a specific policy on food labelling by the food industry there was an intense field of interests and conflicts. It happened because PNAN guidelines refer to the issue of healthy nutrition. This approach does not refer to access to food. It would be necessary to manage the environment, which means controlling the advertisement, making information and the nutritional labelling accessible to the consumer. At that time, Brazil decided to make laws to impose food labelling. It was done only in two other countries: United States and Israel. In other countries labelling was voluntary. The Brazilian problem on nutritional labelling refers mainly to the commercial interest of the industries to supply the end-user with the right information.

There was a need to democratize information to the end-user regarding all ingredients contained in the food to be consumed, so that he/she could make his/her own choices. “Then, this information must be democratic. All food must inform the amount of calories. The consumer has the right to choose to consume a high or low

calorie food. Normally people know the amount of calories when it is interesting for the industry, because it has no vitamins."

The concern with food labelling in Brazil derives from the PNAN implementation process, whose formulation and implementation processes were simultaneous. The opportunities appeared and the technicians involved in the process introduced ideas and tools the State needed to act in relation to the Food and Nutrition Policy.

> Labelling legislation started with a proposal. The process was interesting because we made a proposal and the industry resisted a lot. It was not practicable, the consumer would not understand the labels. We decided to use a methodology that defined the amounts by portions. It was completely revolutionary. No other country had ever done anything similar. It worked and when the industry felt the Ministry was really decided to impose food labelling, their attitude toward it completely changed (…).

In regard to the Brazilian cultural diversity, the policy did not progress as to the diversity of regional and local, rural and urban feeding practices. The cultural issue is a lack from the past and the present. No one could understand health in its symbolic aspect, which is translated into cultural feeding practices.

> To ignore culture is to reject some issues on the information, education and communication areas, which are weak aspects of politics.

In what regards the prevention of chronic noncommunicable diseases within PNAN, it is interesting to notice that it was more a question of the people who were discussing it than of the sectors within the Ministry that dealt separately with these diseases. In the opinion of a key informant,

> we were also considering those data on overweigh that was growing and the clear association between food and other diseases and hunger. This was the most important subject in the nutrition area. We began looking at these sectors. It was not their demand to policies.

In the opinion of a key informant, an idea that needs to be considered at PNAN and that Brazil needs to solve is a kind of code of ethics for the relationship between

public and private sectors. It is not possible to ignore the role of the food industry in this context.

> How can we have a relationship with this sector if we consider that, apparently we have different interests in this process? Industry wants to sell or produce food with the greatest profit it can have. I think there is no code for the relationship between the two parts and this is necessary because we have to work together, to join efforts.

Not only in the food and nutrition areas, but also in the public policies sectors, public managers have difficulty in dealing with the private enterprise since “the tendency it to retreat and avoid a lot of dialogue because of the fear of a conflict of interests. It is even worse in a moment of crisis such as the one we are living now. This is something that politics does not approach and we will have to deal with soon”.

Food industry that does not create and produce healthier food will have a lower profit. This is a world tendency, since

> those who are investing in a food segment and are not seeking a healthy product will loose money in the next decades. People are demanding quality stamps to attest that such a product is healthy for their heart, their stomach ... People are becoming more and more aware of this. We will then see a struggle because some industries will offer healthier food within this market and will jeopardize other industries. When this group meets to draft a policy, everybody listens to it. Social control will determine if it will progress or not. Social control is in the hands of the buyer. If a group feels impaired, the buyer (the consumer) will determine who is trustful. The buyer is thus well informed and can define the process.

Incoherently, other discourses of the actors involved indicate that the Food and Nutrition Policy is far from being what one may wish. In fact, by the end of the 1990s, among the policy makers of this specific policy and even among the actors that discussed and inserted this issue of food and nutrition security, the link between diseases and food was not much evident. It was focused on hunger, lack of food, malnutrition, deficiencies, everything regarding lack of food, inadequacy of food. The impacts they could have on chronic diseases were not clear. These were ideas defended by the co-workers of university centers that participated in the whole process.

“It was included in the agenda, but was not really included since other areas of the Ministry did not want to be subordinated to the food and nutrition area because it did not have an importand status in the Ministry”.

Considering the ideas based on evidence, the actors emphasized that the present PNAN might be improved in what concerns the prevention of chronic noncommunicable diseases. ”Overweigh *is becoming a huge problem”.* It reappears by the end of 2004 with the Global Strategy for Healthy Food (WHO, 2004) with data showing that there are 40 million people with overweight, both adults and children. An interviewee said,

> Much more attention should be given to these data and to the formulation of hypertension and overweigh issues. We know that the diseases that are killing more people are those related to heart problems. Thus, this issue needs a formulation considering health issues—not only regarding feeding—for its becoming a morbidity close to first world rates.

6.3 Interests

Policy-makers receive information from various sources, although some sources are individuals that express their personal opinions (activists), others represent a general opinion of groups of individuals. For example, interest groups represent professional associations (doctors, nurses, teachers), citizens or industrial sectors. With governmental agencies, the several parts interested constitute communities with the same interests related to specific policy areas (health, education, agriculture).

Within these communities, small groups of interested people interact to deal with specific issues of policies such as to promote the publication of nutritional information in food labels or to include physical activities in schools. The specific interests and the way they interact may vary according to the issue. The interest groups focused on specific issues and the way they interact are called political networks or political communities.

In some cases, the government may assume the leadership in promoting a change in specific issues. In other cases, the government may not be willing to be the leader of a change in the policy or may not have the necessary resources. One or more interests outside the government may insist the change be made.

Although the interaction between the interests and the policy makers is more common by formal ways, it may also be done in an informal way. For example, a policy maker may have acquaintances with a specific group of interest and may talk informaly to that group, in a social or public event, about a certain issue.

Interest groups are always trying to present their perspectives on given issues to relevant policy makers. Some of these groups are well organized and have considerable resources. Normaly, this ability allows this group to influence on the process of policy formulation more than other groups with fewer resources. To a certain extent, governments depend on interest groups with considerable resources to help them decide on what to do in a specific issue. Governments may also depend on these groups or individuals to help them implement the decisions regarding the policies. (Atkinson, M.M. & Coleman, W.D, 1992).

The first conflict in the area of regulating measures in the PNAN implementation phase was related to food labelling in Brazil. It refers to a discussion among State, society and local and international markets, involving discussions within Mercosul and the World Trade Organization (WTO) as stressed by a key informant:

> We had an internal resistance. We overcame that resistence, started acting and did something interesting. It was a good proposal, but we had to harmonize with Mercosul and this was the second barrier. This showed us that a greater international issue was easier to be included in the agenda, especially if it was a national regulatory agenda. Otherwise we could not go forward. Dealing with the food issue in the legislative is dealing with international food trade and with the whole international system.

Little by little, the Brazilian technicians that participated in the WHO sessions interacted with the international CNCD area. At that time, Brazil was going through a phase of implementation of PNAN actions on healthy feeding and needed international support. Within this process, there was the mobilization of WHO technicias interested in the tobacco issue and this was the first opportunity (KINGDON, 1995) to get an international support. This was the first movement within the guidelines to promote healthy feeding and physical activities as a strategy to combat CNCDs in Brazil.

This mobilization for the approval of a healthy nutrition as a component of the prevention, control and surveillance of CNCDs began with the actions regarding the damages caused by smoke to the quality of life. Thus, the legislation on the production and consumption of tobacco with a regulatory component was the beginning of the international mobilization.

WHO technical area, after including the tobacco issue in the international agenda, began an internal mobilization to regulate the issues on healthy food and physical activities within the institution. Within this context, Brazil received the crucial support of WHO to define this strategy, considering that

> we need an update of the scientific basis, since without a sound scientific base we cannot fight the others. Second, we need an international instrument agreed among countries that define the area of action and give us political power. We can do it in Brazil but we will need a greater international political support.

After the Brazilian mobilization, other countries could include this issue in the agenda. The Ministry of Health, by means of the chronic diseases area, organized in 2002 a meeting with the WHO representative who was very interested in the movement that was taking place in Brazil.

This international meeting aimed at mobilizing WHO institutional interest. “We brought different experiences from states and municipalities to show WHO representatives the movement we were doing in Brazil”.

Thus, there was an opportunity: “it was a very well organized meeting that brought a series of ideas confirming the importance of this movement”. Thus, Brazil had

a central participation in the Global Strategy formulation process. “Brazil was not the only country to participate, but its participation was very important with my initiative and later on with their visit. Then, they decided it was important to organize a Global Strategy to promote healthy feeding".

At WHO meeting in 2002, Brazil and other countries joined and made an argumentative and persuasive effort, based on empirical evidences and on the acquisition of institutional space for ideas and interests. Then, other countries approved a resolution for WHO to organize a Global Strategy. From this process resulted the formation of an international reference group with the participation of the scientific community and professionals of the programming area. Brazil was represented in the international work group by a technician from the public health area that belonged also to the academic area. But “they invited me to focus on a public health perspective from the program point of view, a less scientific and more pragmatic one” says an interviewee.

Other international organisms such as FAO and UNICEF participated of the group. This group was nominated to work with WHO, with a view to formulate the regulations of the Global Strategy for Healthy Feeding and Physical Activities, as from 2002. It is confirmed by a key informant that “we worked for about two years, in terms of process, similar to the PNAN policy formulation process in Brazil”.

The process of Global Strategy organization began with the development of a technical document, based on the PNAN model, as a first draft. This document was discussed regionally, according to the regions established by WHO. Each of the regions discussed the document under the perspective of their specific demands. At the same time, WHO was discussing with non-governmental organizations in order to catch the consumer’s perspective. The discussions involved also the private sector. The formulation process of the WHO Global Strategy was concluded with a final text approved in 2004.

Thus, it is evident that the PNAN formulation and implementation process from 1999 to 2004, especially within the healthy feeding guideline, contributed to the

formulation of a Global Strategy in 2004. Partly, as a national public policy, PNAN was strengthened with the Global Strategy. Partly, the Global Strategy was also built and strengthened based on the experience of member countries, as stressed below:

> By the other hand, the Global Strategy is based on the experiences of the countries. It is a two-way process. We needed an international support. Now that I am at this side, looking the reality, the experience, the practice of the countries, for example, one thing I asked the Ministry was recently launched: the “New Brazilian Food Guide”. The slogan created by the Ministry was “Feed your Health”. I think it is wonderful. It is a basic concept and says everything. This is a product of something shared with the states, discussed with them, voted and, even better, a concept that was worked together, which is therefore recognized. It was already translated to all languages with a headline thanking Brazil for having offered this slogan.

6.4 Institutions

While talking about public policies we consider not only the perspectives of the State in action (projecting the process by which are established and put into practice the programs and actions translated into political-administrative devices coordinated around explicit objectives: Muller & Surel 1998), but also the actions or omissions of the State in relation to the demands of the society (O´Donnel, 1982, 1986).

The institutions, in the policy formulation phase, are the structures and formal processes by means of which the policy makers decide on public policy issues. Among the formal structures are: the political businessmen; the legislative, burocratic and judiciary branches of the government; the formal rules created by legislation; the regulations and legal decisions; the formal governmental structures and processes including ministries and agencies (Rothstein, 1998).

The way the government is organized may have a significant influence on its ability to react to public health issues. For example, the traditional organization of the Ministries of Health of various countries makes them concentrate only in complying with

the legislative demands to finance hospital services and doctors. This focus may cause a delay in the recognition of other options to promote health and prevent diseases and in the use of public resources to keep people healthy.

The reality of dissonant organizational mandates and the lack of experience to overcome the sectorial limits to create harmonized policies is an obstacle to determine an approach in the formulation of policies (Lavis *et al* 2001).

Although different alternative ways for evaluating the health sector have been suggested in the literature (McKay, 2001) the existing liability created by the present legislation and the corresponding structures and processes may have created a greater tendency against the consideration of new ideas on the policies. Non traditional organizational approaches may be a critical factor in the govenamental ability to efficiently respond to the present and comming issues related to public health (DESVEAUX *et al*. 1994).

PNAN elaboration process as already analysed, was commenced in the scope of the Ministry of Health, a place where the political guidelines were built, debated and negotiated among governmental policies managers, civil society actors and the market.

As a starting point for the negotiations, corrections and argumentations it was requested from a group of the food and nutritional area specialists, former workers of the National Institute for Food and Nutrition, to develop a basic document containing elements of scientifical evidence to confirm the arguments and the necessary persuasions to formulate public policies. As Majone says, public politics is made of words. In a written or verbal way, argumentation is basic in all stages of the policy formulation process (MAJONE, 1997, p.35). Based on this first document that would have an argumentative power based on empirical evidence about food and nutrition problems, the technicians responsible for the area had three long meetings with representatives of governmental institutions and of the civil society.

> I believe this was the first large experience that was not vertically imposed, from top to bottom. It was debated and agreed by with the contribution of several institutions.

According to Majone, in every organization, public or private, discussion is a continuous process. The author argues that the discussion process, aiming at convincing the others, goes through the whole political system. This process, within the organizations, is so evident that it is found both in the fundamentals of politics and in the democracy. And democracy is a government system based on discussions. Both state and society actors interested in the political area, such as the political parties, the legislative, the executive, the courts, the media, the interest groups and the independent specialists interfere in the continuous debate and mutual persuasion process (Majone, p.35).

We could then ask: How did this process to persuade and influence specialist technicians, based on a basic document on the need to establish a specific policy in the food and nutrition field work?

As mentioned in the item concerning the historical process to form and constitute a public agenda on food and nutrition in Brazil, the majority of the actors interviewed argued that, after the extinction of INAN, the nutrition area was too fragmented within the Ministry of Health. Other related areas and the distribution of responsibilities of different programs were also fragmented, for example: the child nutrition area assumed some programs and the National Health Foundation assumed others.

The process for extinction of INAN and the subsequent fragmentation of actions in the scope of the Ministry of Health caused discontentment within the nutritionists community. Not only among those who worked in technical areas of the Ministry of Health but also nutritionists who worked in other states of the country. The decision caused indignation in the national scientific community echoing in international organizations within this area.

At the institutional level, the food and nutrition area had three indispensable elements to formulate the policy:

a. a national issue translated in the epidemiologic relevance of the issue and included in the public agenda, to respond to socially raised demands in the public health area;

b. a favorable opportunity within the Ministry of Health, with a view to reorganize the food and nutrition area (human resources, technicians, budgets);

c. the political pressure of state and civil society actors interested in redefining the State actions in what regards food and nutrition.

PNAN was the second policy ruled at the Ministry of Health by Directive No. 710, of 10 June 1999. It represented a political-administrative, institutional and sectorial decision, related to food and nutrition problems, as well as to institutional problems caused by the depletion of INAN until it was totally extinct.

In fact, there were three parallel processes to be done: First, to reorganize the food area in an administrative, technical and political way; second, to delineate and define the food and nutrition policy for the whole country and; third, to continue with the governmental actions still under way, even with the extinction of INAN, as confirmed by this interviewee:

> Within the PNAN policy formulation process we could not wait for its regulation to reorganize the programs. By the other hand, we could not reorganize the programs at the Ministry of Health without a political base with a sound support to move it (…) From the administrative point of view we started to collect again the different actions of nutritional interventions that were scattered at the Health Policies Secretariat.

From the political-institutional point of view, as argued by the technical area personnel, the fragmented actions concerned child nutrition, began with breast-feeding and complementary nutrition, programs to combat malnutrition, nutritional deficiencies, and included programs in the micronutrients area: Program to reduce the use of salt, program to distribute vitamin A. There were also initiatives to combat anemia.

This moment of crisis, during the phase of reorganization of food and nutrition actions within the institutional scope, favored the dialogue between the areas of

formulation and implementation of policies. As a starting point, began the discussion on the need to promote the prevention of adequate feeding and to structure actions, already aiming at the prevention of chronic diseases. In fact, the food and nutrition area, within these circumstances, started a conversation with the chronic diseases area in actions related to food for diabetics and hypertensive people.

In 1998, some actions were already implemented and began the PNAN formulation process. That is, policy formulation and implementation processes occurred simultaneously.

In the Health Policies Secretariat at the Ministry of Health, at that time, the process of policy formulation began as part of the methodology established by the technical area to delineate and formulate public policies in the health area.

Such methodology began with the establishment of a technical document, requested to three technicians whose names were a reference in the nutrition area. They made the first draft. The basic document described the epidemiologic chart of the problem, the policy proposal, its guidelines and the responsibilities of each SUS partner.

After the elaboration of the basic document, it was necessary to submit it to the appreciation of State and society actors and to the market interested in the area. As argues a key informant, PNAN formulation and approval institutional process

> was a very inclusive action, since this was the objective of the policy formulation process. Therefore, the leadership of the administrative area, that is, the reorganization of programs parallel to the project to reformulate the policy was interesting. The inclusive process to formulate a policy was mirrored in the way we were reconceiving the programs and redrawing, improving or maintaining them.

This basic document was also presented in a discussion event organized by PAHO. In this event were identified the main actors of the nutrition area, especially those linked to the Executive Power.

After the identification of the actors interested in the area, the commission formed to establish this policy invited other ministries, actors from the legislative power and the

civil society, including organized movements, the food private sector and scientific and international communities.

In regards to the civil society actors, the interviewees stressed the importance of the consultation done in the National Forum on Food and Nutritional Security (FBSAN) which had a wide representation of the society with people coming from the Citizenship Action Against Hunger and Poverty (1992-1994).

FBSAN was created in 1998. Among the main objectives and actions implemented during its life are (FBSAN, 2003):

a. To mobilize society around the Food and Nutritional Security issue and to cooperate with the formation of a favorable public opinion on this perspective.
b. To promote the establishment of national and international political proposals and actions on Food and Nutritional Security and Human Right to Food. To insert this issue in the national, state and municipal policy agendas and to cooperate to the international debate on the subject.
c. To insert this subject of Food and Nutritional Security in the agenda of governments in different levels.
d. To instigate the development of local/municipal actions to promote Food and Nutritional Security.
e. To cooperate with the qualification of civil society actors with a view to improve the effective participation of society in the different social management scopes.
f. To denounce and monitor governmental responses as to the violations to the right to food.

The National Forum on Food and Nutritional Security comprised 120 non governmental organizations interested in the responses to hunger and poverty problems and on food and nutritional insecurity problems in Brazil. The contribution of this forum was significative, not only regarding the content, but also regarding the inclusion of other

organizaitons that were separately invited such as the Brazilian Association on Nutrition (ASBRAN) and the movements organized by nutritionists. These, besides participating of the forum, had also a specific participation, not only through the forum but also as representative entities interested in the policy formulation.

As stressed by a inteviewee,

> “it was a mix of participation as representative and direct participation. We estimate there were about 120 organized groups that participated in the debates. The private sector was also there and its participation was considered important to the debate since the beginning so that it could assume responsibility in the whole agenda.

At that moment, the movement of the nutritionists was relevant to the political scene. In a congress on nutrition in Brasília, by means of the press, they called the attention of the society to the importance of the human right to food, of the incorporation of food as a right and, thus, helped incorporating this discussion in the policy draft.

The work meeting held by PAHO in 1998, as the first opportunity to share a purely technical document in a forum of political nature was convenient for the govenrmental managers to assume that PNAN approach, phylosophy, and central axis should be given to food as a human right.

Thus, at the same time it represented a progress in the conception, ideas and values area, the governmental managers were not sure about how to procede to incorporate this new terminology in the governmental agenda, that is, food and nutrition as a human right. As stressed by a key informant, “how should we deal with that new issue. It is still new. What does it mean conceptually in terms of discourse, and what does it mean in programatic terms. We had little idea about that”.

Thus, it was necessary for the technicians to demand support from the human rights area at the Ministry of Justice. A small writting group was formed to re-read the basic text of the policy under the point of view of human right to food with the support of human right specialists.

At the institutional sphere, at the same time the basic text was reviewed, with the contribution of the different actors interested, Ministry of Health technicians, already organized under the General Coordination for the Food and Nutriton Policy (CGPAN) wanted to test the programatic implications of that discourse still under elaboration (human right to food) based on the following questions: What does this new discourse mean? Is it another rhetoric discourse or does it have a programatic consistency? In the opinion of an interviewee it was a discussion moment that caused many disputes and debates during the policy formulation process. These arguments lead also to the opportunity to, under the pragmatic-programatic point of view, test this discourse in the actions concerning anemia.

The technical area decided to chose anemia as the first example to materialize the human right concept in programatic terms. The methodological discussion regarded what to do to make anemia combat programs contribute to the accomplishment of the human right to food, and, on how we could deal with the anemia problem within this context, within the law framework. Thus, each manager should be called to assume responsibility.

This right implies duties of various actors and these must be agreed on the deadline, elaboration of indicators, decision on the ways to divulge the information and mobilize society, human and material resources allotment, formulation of a results protocol among other aspects referring to the formulation, implementation and evaluation processes of public policies. The agreement was duly signed by the partners in an official document.

In the institutional and actions instruments scope, the change in the conceptual plan also demanded a wide discussion on the programatic implications of the concept of human rigth to food, as a value in the PNAN ideas. A basic question according to the understanding of the interested parties referred to the relationship of the State institutions with the “beneficiaries” of public services. Under the conception of an interviewee, it would be necessary to change the relationship between State, society and market. The subject of the action should not be only a focus of the public policies, it must be also a participant: “A citizen has the right to food. Consequently, the family, the

person, the woman is a participant in the action of which they has a right. They are not only a beneficiary". This change on how to look the receiver of the professional action implies also in the qualification of human resources on how to deliver these services in the health area so that they are aware they are providing a right to the people.

Thus, in the institutional scope, with the approval of PNAN, began a permanent process of qualification of human resources involved in the planning, monitoring and evaluation activities in a descentralized way, as proclaims the Federal Constitution and the Single Health System (SUS). "We qualified all states of the Federation in an interesting process. Later on the States made their own qualification plans for the municipalities and trained these municipalities".

The qualification process, at first, was based on the invalidation of two concepts: nutritional food security and human right to food. The qualification coordination developed a learning methodology in which the participants built the concepts in the light of their own experiences and "began noticing they were able to do something to modify that reality".

Beginning with the learning process, the team started developing opinion researches that culminated in the modification of the main program: milk distribution, an assistance program. More inclusive programs were envisaged, which culminated in PNAN guidelines. PNAN formulation process, as argued by an interviewee, was inclusive, participative and sound. This policy remains up to now as the official policy of the Ministry of Health. "A policy must have a longer life."

The argument on the guidelines referring to human right to food progressed as the discussions on the guidelines for the intersectoriality of food and nutrition policy with the other sectorial policies (education, agriculture, work, social development, among others) demanded an immediate articulation of the area with some sectorial offices involved in the formulation process.

According to an interviewee, a remarkable example refers to the indefinition of the work group in charge of the policy conception and formulation, on the following dilemma:

it was a food security policy that would comprise the whole dimension of food security, from the produciton to the biological use of that food or would it be a section of the health area, a sectorial policy inserted in a wider policy on food security?

A key informant reminds us that it was decided for the second definition, that is, a sector of the health area, due to two reasons: First because the demand of the technicians that year at the Ministry of Health was to formulate a food and nutrition policy to constitute a national health policy. Second, because the technicians considered that the health agenda on food security was still fragile and unfinished.

> We had to define this agenda (...) to do our part well done, to contribute to food security… PNAN was, in fact, formulated as a health policy and was endorsed by the Ministry of Health. Since the beginning it was defined it would be so. That is, at the discussion phase at the National Health Council we noticed that the health area could not support the nutrition issue. But if the health area cannot support the nutrition issue, how can we deal with the intersectoriality and with the policies of the other sectors. Then, the debate was opened to other levels. We contribute to the intersectorial debate and assume the responsibility over the whole actions needed for food security.

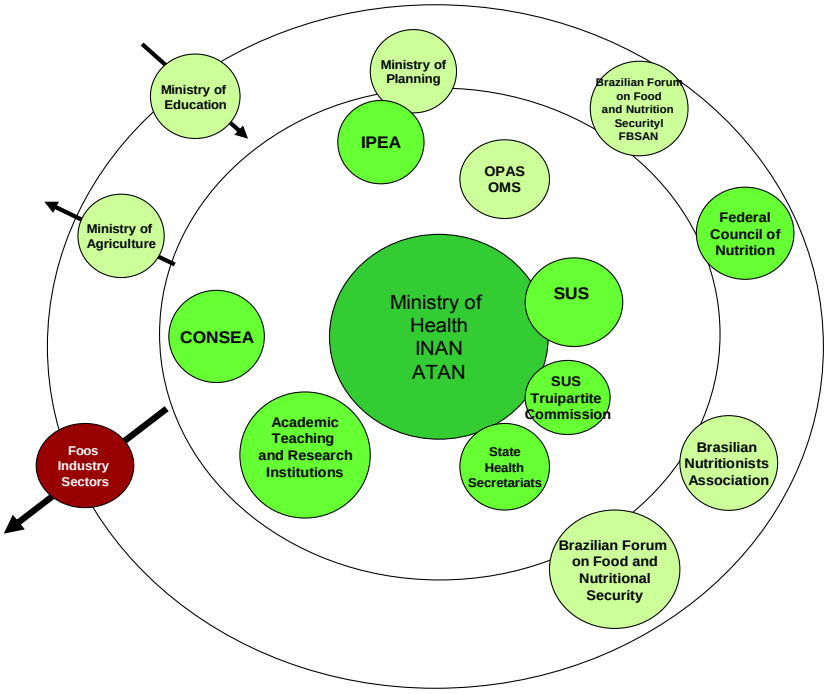
In the deliberation instances about the policy concept, the National Health Council was a main actor. An interviewee infers that when the policy text went to this Council, the need to argue on the intersectoriality idea, on one hand, and the magnitude and complexity of the food security idea, on the other hand, became the main issues of the debate. After this debate and with the strong arguments of the specialists and militants, was born the first PNAN guideline: the need for intersectorial actions to guarantee human feeding. It was a public policy, as a State duty and a right for citizenship, which culminated in the complete PNAN text, ruled by Directive No. 710 of 13 June 1999.

6.5 Policy Instruments and Action Plans Regarding PNAN Guidelines (1999–2005)

According to the analysis diagram of PNAN formulation processes on page 28, the public policies instruments refer to laws, costs, programs and services that materialize State actions in a given intervention area.

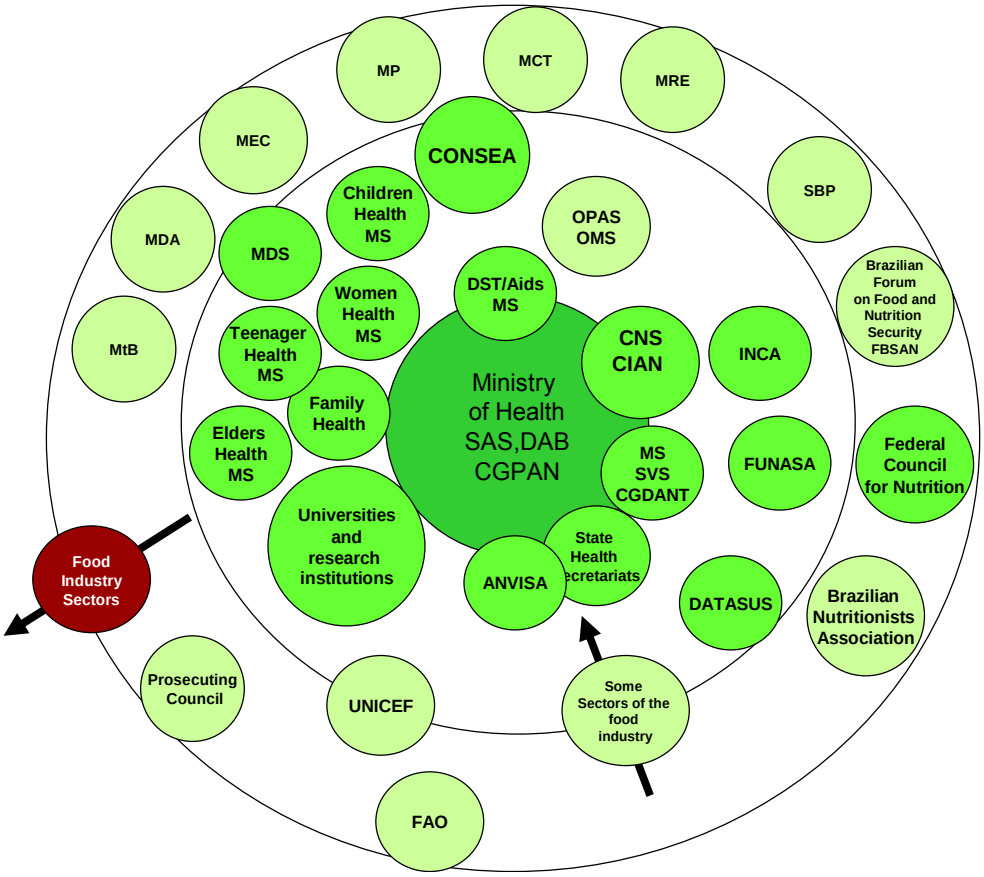
PNAN formulation process evidenced the formation of a community of policies formed by groups and networks with converging and diverging interests on the conception of PNAN guidelines. They were analysed regarding the context, institutions and ideas axis with the main interested entities on food and nutrition issues in Brazil from 1990 to 1999, as shown in the following diagram:

Policy Community: PNAN formulation (1990-1999)



After the approval of PNAN in 1999, different State and society actors became interested in public policies instruments that rule the food and nutrition area, including plans, programs and services. Following are the most important actions devided by area of sectorial policies of the Brazilian government in the 1999-2005 period, as shown in the following diagram

Political Community: PNAN Implementation (1999-2005)



6.5.1 Programs related to PNAN and SAN (1999–2005)

6.5.1.1 Ministry of Health

In March 1998, the Ministry of Health established the Incentive to Combat Nutritional Deficiencies (ICCN), by means of Ministry Directive No. 2.409, of 23 March 1998 (BRAZIL, MS/SAS/CGPAN, 1998).

It was a program of financial incentive for the development of actions to combat malnutrition, transferred to the Brazilian municipalities—from the National Health Fund to the Municipal Health Funds—and as part of the Minimum for Basic Service / PAB.

Based on this Directive that created the Program, the groups of children from 6 to 23 months of age were considered the prioritary groups to receive this financial incentive. Other groups considered were the pregnant women, elders and children from 24 to 59 months of age. The beneficiaries received every month 3.6kg of whole powder milk (or 30 liters of sterilized liquid milk) and one liter of soy oil for each child between 6 and 23 months of age. For each child within this age group, thus, was given an amount equivalent to R$180.00 (reais) per year on milk and soy oil. Additional resources corresponding to 50% of the amount transferred to the nutritional care of children between 6 and 23 months of age were also invested in each municipality to serve other populational groups (pregnant women, breast-feeding mother, children with more than 24 months of age, elders, etc) or to establish other adequate food and nutritional promotion actions.

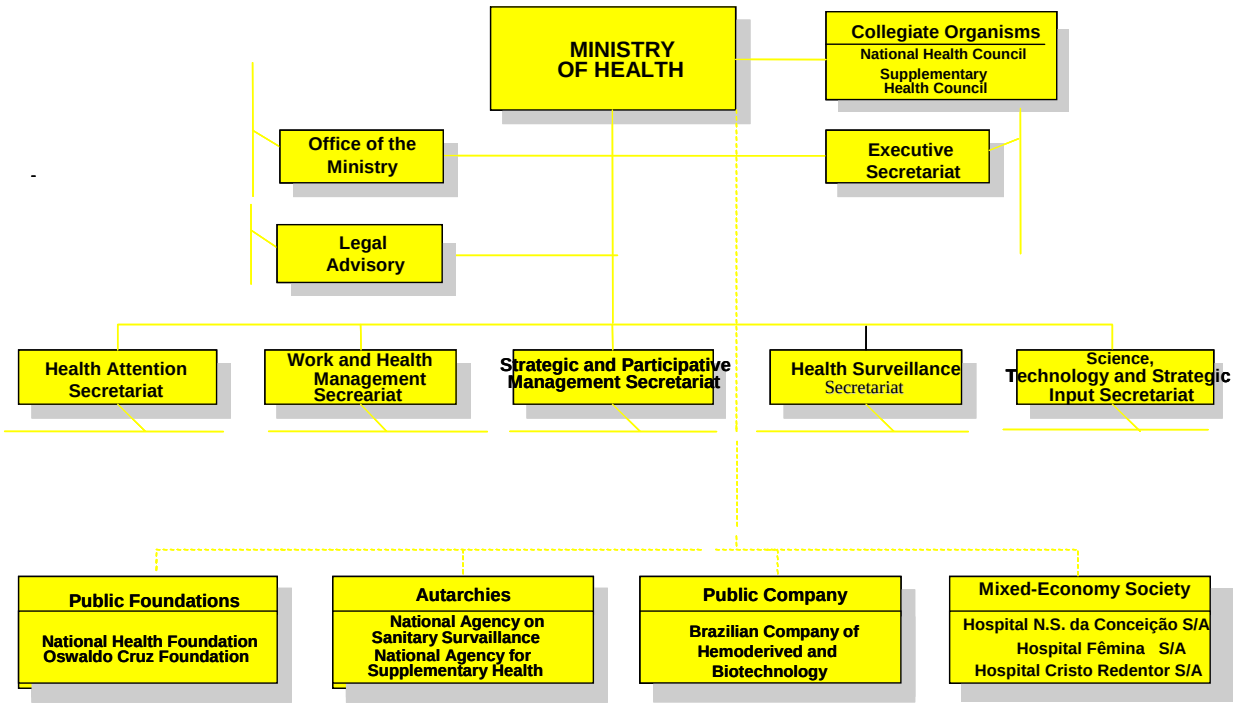
In 1998, year in which it was established, ICCN coverage comprised 3.225 municipalities, reaching 597.725 beneficiaries. In 1999, it was increased to 4.793 municipalities, reaching a total of 850.013 beneficiaries. In 2000, it reached 871.098 beneficiaries in 5.026 municipalities. Up to December 2001, 5.127 municipalities were qualified and served approximately 880.000 children, pregnant women and elders. By the end of 2001, ICCN reached 92% of the Brazilian municipalities, serving 95% of the total of beneficiaries as expected (922.536 beneficiaries). Since the establishment of ICCN in 1998, the yearly financial ceiling was of R$167 million (reais). In the 1998-2002 period, were transferred about R$574.60 million (reais) as an Incentive to Combat Nutritional Deficiencies (BRASIL/MS/CGPAN, 1998).

According to ICCN history, organized by CGPAN during its existence, the following results were observed: a) increase in the percentage of children benefited with up-to-date vaccination; b) increase in the percentage of children and pregnant women benefited with up-to-date weight evaluation; c) increase in the percentage of pregnant women benefited with up-to-date antitetanic vaccine; d) increase in the number of pre-natal visits to the doctor among the benefited pregnant women; e) increase in the percentage of parents that take part in educational activities; f) increase in the

percentage of women able to properly correspond to breast feeding and healthy feeding practices; and, g) increase in the quality of the information given by the mothers.

In 2001, by means of Provisory Measure No. 2.206 of August 2001, was created the National Program on Minimam Income, linked to the Health area—Food Allowance Program (PBA). As informed by CGPAN (2003) report, there was a huge participation of the Brazilian municipalities up to December 2002. This inviabilized the maintenance of both programs (PBA and ICCN). Due to that, in October 2002 was taken the administrative decision with the publication of Directive GM/MS 1920 deciding that "as from January 1st, 2003, the money transfers referring to Directive GM-MS 709 of June 10th 1999, aimed at the Encouragment to Combat Nutritional Deficiencies / ICCN—would be terminated".

In 2003, the Ministry of Health already had an organizational structure defined, as it is nowadays:



In the organizational structure, the food and nutrition area is linked to the Health Service Secretariat, which has the following competences (Art. 13, *cf.* Decree No. 5,678 of 18 January 2006).

I. to participate in the formulation and implementation of the health service policy, observing SUS principles and guidelines;
II. to define and coordinate the integrated health actions and services network systems;
III. to establish norms, criteria, parameters and methods to control the quality and evaluation of health service;
IV. to supervise and coordinate evaluation activities;
V. to identify the reference services to establish technical patterns for health assistance;
VI. to formulate and propose norms to regulate the relations between SUS management levels and the private services hired for health assistance;
VII. to coordinate, follow and evaluate, in a national scope, the activities of serice units of the Ministry;
VIII. to render technical cooperation to improve administrative and operational qualification of States, municipalities and the Federal District;
IX. to coordinate the formulation and implementation of SUS assistential regulation policy;
X. to promote the development of strategic actions aimed at reorganizing the model of health services, taking as structural basis the basic health service actions; and
XI. to participle in the formulation, implantation and implementation of norms, instruments and methods that strengthen SUS administrative capacity in the three governmental levels.

Presently, SAS structure includes five departments and one institute, namely:

1. Department of Specialized Services;
2. Department of Regulation, Evaluation and Systems Control;
3. Department of Basic Service;

4. Department of Strategic Programatic Actions;5. National Cancer Institute;
5. Department of Hospital Management of Rio de Janeiro State.

Food and nutrition contents are responsibility of the General Coordination on Food and Nutritional Policy (CGPAN) which reports, in the structure of the Ministry of Health, to the Department of Basic Care of the Health Care Secretariat.

Its mission is to program actions according to the guidelines of the National Policy on Food and Nutrition (PNAN), some of its attributions being:

I. to plan, guide, coordinate, supervise and evaluate the process of implementation of the National Policy on Food and Nutrition, aiming at improving the nutritional conditions of the population during its lifetime and observing the principles and guidelines of the **Single Health System- SUS**.

II. to propose, plan, normalize, manage, monitor and evaluate, in the national level, the execution of plans, programs, projects, actions and activities needed to carry out the National Policy on Food and Nutrition;

III. to articulate with States, Municipalities and the Federal District, in order to promote their commitment to programs and projects in the area of Food and Nutrition and to perform technical cooperation to improve managing and operational ability in the area;

IV. to promote the articulation with national and international finance and research departments, entities and agencies, for the development of cooperation projects, studies and researches on food and nutrition;

V. to promote and stimulate continued education for human resources involved in the implementation of all PNAN programs and projects;

VI. to foment and to take part in intersectorial activities for the planning and implementation of sustainable food and nutritional security activities, projects, programs, plans and policy.

Thus, CGPAN plans actions in the field of food and nutrition, following PNAN guidelines and their performance in state and municipal levels, highlighting the Healthy Nutrition Promotion (PAS), which aims at supporting Brazilian states and municipalities in developing actions and approaches that contribute for health promotion and disease prevention.

According to the responsible government manager, in the Ministry of Planning level, responsible for the management evaluation of the Healthy Food Program, (Brazil, Ministry OF Planning, 2002):

> In January, 2000, the Incentive to Combat Nutritional Deficiencies (ICCN) had been implemented in 87% of the 5,507 Brazilian municipalities, estimating 850 thousand beneficiaries (92% of the maximum coverage foreseen). ICCN resources transferred to the municipalities in 1999 surpassed the amount of R$ 127 million. In year 2000, more than R$ 152 million were invested in combating nutritional deficiencies. In that year, the Healthy Food Program was structured in four main actions and the sources had been foreseen by 2000–2003PPA. During the period 2000–2002, there was no continuity problem in the financial flow which could hinder the execution of the Healthy Food Program. The funds belonging to the Healthy Food Program suffered no interruption in year 2002. There was no continuity problem in the financial flow which could hinder the execution of the Healthy Food Program. Even so, the fulfillment of the goals was below the forecasted. Material and infrastructure resources, as well as human resources, are appropriate for the implementation of the Program. There were no changes in the budget law in 2002 that could affect the Healthy Food Program.

6.5.1.2 Food and Nutrition Surveillance System (SISVAN)

The Food and Nutrition Surveillance System (SISVAN) was announced in the 1970s, during the World Food Conference (Rome, 1974) and it was recommended by WHO, PAHO, FAO and UNICEF, aiming at: “(...) monitoring the conditions of less favored groups of the risk population, and providing a fast and permanent assessment method of all factors influencing food consumption patterns and nutritional situation” (FAO/WHO, 1974).

In Brazil, the beginning of SISVAN implementation was in 1977, when the organization of an information system for the surveillance of food and nutritional situation of the Brazilian population was proposed. Its regulation came later on, in 1990, by Directive No. 080 of the Ministry of Health (16 October 1990) and it was considered a pre-requisite to the transferring of federal funds to actions combating malnutrition. Today, there is Directive No. 2246 of the Ministry of Health, of October, 18th, 2004, which establishes and divulges basic guidances for the implementation of Food and Nutrition Surveillance, among the basic health actions of SUS all over the Brazilian territory. The three theme areas initially proposed by SISVAN, in Brazil, were:

- Nutritional situation / Specific deficiencies
- Food consumption
- Service quality and performance

These thematic areas aimed at providing information to plan actions for the prevention and control of nutritional disturbs of the population.

SISVAN was conceived mainly to gather information to subsidize public policies improving nutrition conditions of the population; to maintain an updated diagnosis of the Brazilian nutritional situation in what concerns relevant public health problems in the field of food and nutrition; to identify geographic areas and population groups at risk, evaluating time tendencies of the detected problems and gathering data to identify and ponder the most relevant factors for the genesis of these problems.

SISVAN is particularly important for the food and nutrition area, since:

> Nowadays, SISVAN strategic and doctrinal principles have become particularly opportune, pertinent and relevant, since in 2003 was formalized the nutritional and food security recognized as the greatest priority of the government and Brazilian society. In the field of Health, this role becomes especially important, considering the dynamic process of Food and Nutritional transition the country experiences. The problems have been diversified, universalizing several demands for all ages and all socio-economic layers. (Batista Filho, 2004)

The National Policy on Food and Nutrition proposes SISVAN the monitoring of the nutritional and food situation, aiming at facilitating its procedures and expanding its coverage all over the Country. The consolidation of the system is done, especially, with the support of the Food and Nutritional Cooperative Centers spread throughout the country and of the Food and Nutritional State Technical Departments present in every Brazilian state and in hundreds of municipalities in the country.

The role of SISVAN includes the continuous description and prediction of tendencies in food and nutritional conditions of the population, as well as their determinant factors. In the monitoring of food and nutrition, the System must focus on pregnant women and on the growth and development of children, being a basis for every work performed in the service network, especially regarding basic health care and bearing in mind the commitment to its universalization. In what concerns the service network, SISVAN must be incorporated by the service routines, monitoring the nutritional situation of each user, aiming at detecting risk situation and the prescription of actions to prevent its effects and at guaranteeing the reversal of the situation to its normality. Another priority is to map deficiency endemics, in a way that their distribution in space will be evidenced and that there will be an indication of the magnitude of proteic-energetic malnutrition, anemia, and hypovitaminosis A and iodine deficiency, besides the follow up of chronic noncommunicable diseases related to nutrition and life styles considered inappropriate.

Therefore, the mission of SISVAN is to bring forth a basic number of indicators capable of signalizing events of greater interest, such as: food availability, qualitative and quantitative aspects of diet, breast feeding practices and characteristics of the complementary diet post-breast feeding, birth weight distribution, prevalence of proteic-energetic malnutrition, anemia, obesity, iodine and vitamin A deficiencies and other micronutrient deficiencies related to chronic noncommunicable diseases.

6.5.1.3 Brazilian Health Surveillance Agency

Since the 1980s, the growing participation of the population and of entities representative of several segments of the society in the political process molded the current idea of Health Surveillance. According to the constitution, it integrated the activities contemplated so that the Government plays the role of guardian of consumer rights and provider of health conditions for the population (EDUARDO and MIRANDA< 1998).

Thus, the creation of a Brazilian Health Surveillance Agency (ANVISA), in 1999, by Law No. 9,782/99, became a government priority. The attributions of Health Surveillance are described among the competences of the Single Health System (SUS), Artlcle 200 of the Federal Constitution, i.e. “to carry out health and epidemiologic actions, as well as those concerning the worker’s health”. The performance of these health surveillance actions is included among SUS field of actions—Clause I, Paragraph “a”, Article 6 and is part of the Health Surveillance National System defined by the law that created the Brazilian Health Surveillance Agency.

Brazil has a sophisticated Health Surveillance National System (SNVS). The System is composed by the Ministry of Health, the Brazilian Health Surveillance Agency (ANVISA), the National Council of Health Secretaries (CONASS), National Council of Municipal Health Secretaries (CONASEMS), State, Municipal and Federal District Health Surveillance Centers (VISAS), Public Health Central Laboratories (LACENS), Health Quality Control National Institute (INCQS), Oswaldo Cruz Foundation (FIOCRUZ) and State, Municipal and Federal District Health Councils.

The health surveillance actions directly related to nutrition are two:

a. food labelling; and
b. food security.

a) Food Labelling

Food labelling has been frequently discussed nowadays. According to the legislation (Directive No. 42, 14 January 1998) as of 18 September 2001, food labelling must be standardized.

A number of actions were started aiming at the promotion of a healthy nutrition for the Brazilian population. These actions, at the same time, facilitate the control of chronic noncommunicable diseases and their risk factors also contribute to the improvement of the nutrition situation of the elder population. Nutritional contents presentation has become mandatory on labels of every food item package facilitating great publicity of several information and educational measures.

Starting with this effort, the Ministry of Health has edited various regulation tools, as seen in Annex 4.

Besides the directives above mentioned, the following deliberations were also created, taking into consideration the goals determined by PNAN:

- RDC Resolution No. 28, 28 March 2000. Approves Technical Regulation for Good Manufacturing Practices Basic Procedures and Health Inspection Guidelines for Salt Processing Companies.
- RDC Resolution No. 53, 15 June 2000—(Brazilian Official Press, 19 June 2000). Establishes the Technical Regulation on Identity Fixation and Mixture Quality to the Basis of Cereal Bran.
- RDC Resolution No. 91, 18 October 2000 (Brazilian Official Press, 20 October 2000). Approves Technical Regulation for Identity Fixation and Quality of Soy Based Foods.
- RDC Resolution No. 39, 21 March 2001. Approves Reference Value Table for Food and Drink portions packed Nutritional Labelling ends.

➔ RDC Resolution No. 40, 21 March 2001. Approves Technical Regulation for Mandatory Packed Food and Drinks Nutritional Labelling, standardizing the the statement of nutrients.

b) Food Security

Security of food offered for popular consumption is one of the Public Health challenges. Thus, the National Health Surveillance System, coordinated by ANVISA, in its actions in the food control area, prioritizes the Modern Systems of Health Inspection Human Resources Training Program, started in July, 2001, in partnership with the Pan-American Health Organization (PAHO).

Training courses are divided in four stages: a) Good Manufacturing Practices (GMP);b) Standard Procedures for Operational Higiene (SSOP); c) Hazard Analysis and Critical Control Point (HACCP); d) Auditing and Methodology.

The knowledge of knew inspection methodologies and tools and of the educational process passed onto state health surveillance services technical workers allowed its multiplication to the technical workers of municipal surveillance centers. In this manner, it was possible to increase the coverage and speed up the actions aiming at: a) evaluating practices adopted by manufacturers and service providers in the food business; b) interferring in chemical, physical or biological hazard contamination risk situations, or in case of possible damage due to food offered for consumption (BRAZIL, MS/Anvisa, 2006).

6.5.1.4 Ministry of Education

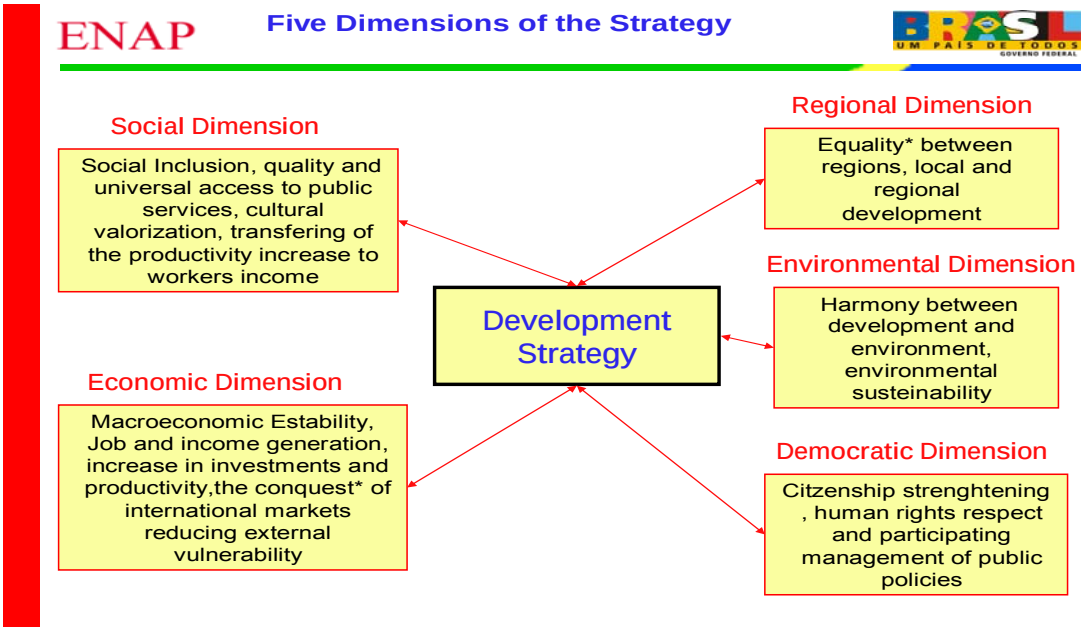
SCHOOL SCHOLARSHIPS

By Law No. 10.219 of 11 April 2001, the Minimum Income Program connected to education was created. It was called School Scholarship and its idea was to grant a monthly money benefit to thousands of Brazilian families in exchanging for the maintaining of their children at school.

According to 2002 evaluation report of the School Scholarship Program (BRAZIL, 2002), at the end of year 2001 the program had reached 5,470 municipalities, i.e. 98% of the 5,561 Brazilian municipalities. This represented more than 8.2 million children from 4.8 million low income families. During that year R$409,9 million in benefits were transferred to the families. In 2002, the action was expanded, and there were still only 15 municipalities to be reached, out of the universe of 5.561 Brazilian municipalities, and the coverage grew to around 5.1 million families, benefiting approximately 8.7 million students.

6.5.2. Intersectorial Programs in PNAN's Context and Food and Nutritional Security (SAN), 2003–2005

In year 2000, the discussions about Food Security had a new boast when NGO "Instituto da Cidadania" (Citizenship Institute), directed by Mr. Luís Inácio Lula da Silva, gathered 100 experts, resuming food security issues and designing a political project to fight hunger and poverty in Brazil, as one of the strategies of the Pluriannual Development Plan (2004-2007), with five dimensions, as can be seen in the picture below:



Source: Pagnussat, Brasília, ENAP, 2003.

In order to fulfill its social dimension, the 2004-2007 PPA chose as its priorities the fight against hunger and poverty, income concentration, illiteracy, slave work, child work, as well as the reduction of regional inequalities in the country, among other goals of the social area.

One of the first decisions of Lula's government was the reestablishment of CONSEA, on January 30th, 2003. The Council has a consulting character and assists the President in what respects the National Policy on Food and Nutrition (PNSN) guidelines. Decree No. 5079, 11 May 2004, establishes its composition, structure, competence and functioning.

The Council resumes its previous implementation experience started in 1993 and interrupted in 1995. In this manner, it recovers and qualifies the issue of Food and Nutritional Security (SAN), providing it a differentiated political status, transforming it into a strategic governmental element, (BRASIL, MS/CGPAN, 2005, P.54) and having Hunger Zero Program (FUCHS and PASSOS, 2006) as the main strategy in terms of intersectorial articulation to reach the five dimensions of PPA (2004-2007) development.

Starting with the reestablishment of CONSEA work, in the federal level, a network of Regional CONSEA Meetings started to grow around the five Brazilian regions: North, Northeast, Southeast, Middle-West and South), *(Projeto [FAO] UTF/BRA/064/BRA / Termo de Referência 19204).* The mission of this project is to "perform strategic actions to facilitate the implementation and reaching of the results expected by the Hunger Zero Program, in what concerns the political, social and economic spheres of the Brazilian Federal Government." It presents three main goals:

a. to support the implementation and management of the national food and nutritional security policy;

b. to reduce the vulnerability of food insecurity in rural, urban and periurban areas;

c. to implement an evaluation system for Hunger Zero Program.

The inputs for the development of works in the regional CONSEAs are the reports from their regional meetings for CONSEAs in North, Northeast, Middle-West, Southeast and South Brazilian regions; the meetings with officials of the Food and Nutritional Security Secretariat of the Ministry of Social Development and Fight against Hunger (MDS); the meetings with directors of the National Food and Nutritional Security Council (CONSEA) when they take part in CONSEA's Technical and Theme group meetings at a national level, among other work strategies and social mobilization used to face the matter at issue.

There are eight priority areas of food and nutrition safety in the work development of the network of regional CONSEAs:

a. *Human Right to Food:* The defense of the inclusion of Human Right to Food in state constitutions and in the municipal laws; recognition of Human Right to Food in constitutional terms—complementation of article 6 of the Federal Constitution; regulation of the Human Right to Food by Federal law; adoption of the Human Right to Food as reference to the writing of the Municipality Law on Food and Nutrition Security.

b. *Official establishment of CONSEAs:* Establishment of their own budget and guarantee of financial, material and human resources to the functioning of State Councils Secretariats; writing and approval of the Municipal Law on Food and Nutritional Security; increasing the discussion on public policies, not limited to Food Security; creating Theme Houses for specific groups, specially indigenous communities and Afro-Brazilian *quilombola* communities; increase CONSEA's articulation with public agencies connected to Food and Nutrition Security, such as SAN forums; support to the creation of Municipal Food and Nutritional Security Councils; writing of the Plan of Actions of Policies on Food and Nutrition Security; implementation of training programs comprehending members of the council, delegates and the population in general; creation and

implementation of a database of governmental and non-governmental food and nutrition security actions and programs, among other actions.

c. *Social participation policy:* Promote the participation of civil society; promotion of the election of the council members in forums; articulation of the CONSEAs with SAN Forum, other Councils and similar entities; sharing of training experiences; creation of tools so that the CONSEAs exercise the Social Control of The Family Scholarship Program; recognition of the Managing Committees and support to its implementation; Incorporation of the Managing Committees as the basis for the Municipality Councils; creation and implementation of Electronic Networks as a way to integrate and democratize information, promoting and increasing civil society's participation.

d. *Monitoring, evaluation and indicators*: Reaction of a Technical Group to guarantee and follow up polices for specific populations and production aspects, in particular, family agriculture; training of council members and monitoring, evaluation and indicators committee members; incorporation of guidelines from food and nutrition security conferences.

e. *Food sovereignty and international affairs:* Guarantee that the main goal of SAN is Food Sovereignty: elaboration of a map of actions and diagnosis concerning the hunger and food security issue; promotion and support for the implementation of community and school vegetable gardens; promotion of courses teaching the complete use of food items; inclusion of SAN concepts in the school curriculum;

f. *Food production:* Promotion of better understanding of what is Family Agriculture; development of water and environment related activities, seminars, proposals, etc.; discussion about the savannah vegetation in the middle-west region:

1. Rural and urban food habits and the preservation of native plants, giving priority to family and community vegetable-gardens as the production model;

2. Preservation of rural and urban springs; promotion of community and school vegetable gardens; inserting professionals in the schools to assist in food production;

g. *Food access:* Focus on the access policy for ethnical, gender, generation, handicapped minorities; establishment of partnerships with supplying centers to make the best out of food and distribute them later on: respect to regional diversity in the food access policies.

h. *Health and nutrition:* Promotion of children nutritional education, inserting the topic as a school class; integration of SAN policies with nutritional policies; change school food to make it reach a certain portion of children's daily needs; promote a cultural movement intending to resume old food habits.

6.5.2.1 FAMILY SCHOLARSHIP PROGRAM

The income transference program Family Scholarship was established by Provisory Measure No. 132, on 20 October 2003, by the Federal Government. Later on, it was made into Law No. 10,836, 9 January 2004 and regulated by Decree No. 5,209, 17 September 2004. This program associates the transference of financial benefits to the access to basic social rights—health, food, education and social work assistance. Interministry Directive No. 2,509, of 18 November 2004, on its turn, establishes the attributions and rules to offer and monitor health actions related to the condition fulfillment of the families benefited by the Program. It is designed to families in a situation of extreme poverty (with a per capita income of up to R$ 100 per month) and unifies management and execution procedures for income transferring and Single Federal Government Register actions. The unified programs were: School Scholarship

from the Ministry of Education, Nutrition Scholarship from the Ministry of Health, Food Card Program (PCA), and Gas Allowance from the Ministry of Mining and Energy.

In the MDS scope, emergency actions are carried out to specific groups (basic food baskets to camps of landless families, indigenous communities and Afro-Brazilian *quilombola* communities), and also: i) Program for Acquisition of Family Farming Foods (strategic stock replacement, incentive program to milk production and consumption); ii) Expansion of School Meals Programs; iii) Food banks and food and nutritional education programs and programs directed to local policies, managed by the states and municipalities with Federal Government support, together with an organized civil society and aiming ta supporting both urban and rural areas most vulnerable to food insecurity, such as: popular restaurants, community kitchens and vegetable gardens.

An evaluation of the Family Scholarship performance, among the programs with greater outreach to poor populations in Latin America, performed by the World Bank and mentioned by Folha de São Paulo Newspaper, in 2006, shows that “comparative studies done by the World Bank demonstrate that 73% of the benefits reach the 20% poorest Brazilians”, assisting 8.7 million families, and presenting the second largest budget among the programs of the current government, around R$ 5.6 billion.

The greatest challenge of the Family Scholarship Program is connected to the integration of its actions to other sector agencies, such as Health, Education, Labor and Mining and Energy. According to the Citizenship and Income National Secretariat, the Family Scholarship Program has been prioritizing the access of beneficiaries to other government programs, because “since last year (2005), there has been an effort towards integrating Family Scholarship with Literate Brazil (Program). The program already works as an integration point for others” (Cunha, 2006, cf. Folha de São Paulo, 2006).

Besides the education, health and social development programs above mentioned, there are also some other ongoing programs/actions connected to food and nutrition. Among them, there are (Brasil, MS/CGPAN, 2005, pp. 176-184):

- Program on *Agricultural and Agro-industrial Research and Development for Social Inclusion* developed by the Brazilian Agriculture Research Corporation (EMBRAPA), aiming to build a base of scientific and technological knowledge in agricultural activities directed to small size enterprises.
- Also developed by EMBRAPA, the *Food and Drink Security and Quality* Program, aiming to guarantee food safety to consumers, considering the aspects of innocuity, quality and identification of products and sub products of animal or vegetable origin, to promote the quality of agriculture raw materials and to promote vegetable and animal health by means of risk evaluation, surveillance, control and fitozoosanitary fiscalization.
- Science and Technology for Social Inclusion/Support to Research and Development applied to Food and Nutritional Security, program developed by the Ministry of Science and Technology aiming at supporting projects, studies, programs and actions concerning the development of food and nutritional security, for the social inclusion and the reduction of regional inequalities.
- Food access/distribution to specific population groups, developed by the National Food Supply Company (CONAB), although present in the 2004 PPA, has been applied since April 2003, when CONAB was appointed the operational execution agency of Hunger Zero Program (Interministry Directive MESA/MAPA No. 183/03). In an articulated action between the ministries of Social Development and Hunger Combat (MDS), Ministry of Agricultural Development (MDA), Ministry of Agriculture, Livestock and Supply (MAPA) and the Ministry of Planning (MP), having as executive agencies CONAB and MDS.

- *Food Supply/Acquisition of Family Farming Products and Food Security Strategic Stock Operation* Program, created on July 2nd, 2003 (Law No. 10,696 and Decree 4,772), in force since 2003 and aiming at promoting family farming by acquiring their agricultural products and distributing them to people in situation of food insecurity and/or to form strategic stocks.

7. Chronic Noncommunicable Diseases (CNCDs) in the Scope of PNAN and Their Contribution as a Public Health Issue

According to a key-informant, although announced or superficially remembered in the II PRONAN, and in a much stronger manner in the National Policy on Food and Nutrition (1999), CNCDs have, in fact, become a governmental concern, involving several institutions, since 2003.

Before PNAN, there were some programs concerning noncommunicable chronic diseases implemented in the Ministry of Health, although they were:

> extremely fragmented, for example, in the 1970s, there was already the National Cancer Department. In what concerns hypertension and diabetes, there were also some initiatives and, more recently, after PNAN, there was a project to reorganize actions in the area of Noncommunicable Diseases and Injuries (DANTs) that resulted in a survey on the risk population.

INAN has developed many programs of food complementation connected to the services of the basic health network. These programs tried to interfere in the trading of basic products, acquisition and sale of products with low price in places with difficult access to food, and complementation of specific nutritional deficiencies such as anemia, hypovitaminosis A, etc., as stressed by an interviewed player:

> they are historical programs that we are trying to improve and expand the coverage. For example, all the salt consumed in Brazil has iodine added to it. This is a problem that comes from many years ago. The diseases resulting from iodine deficiency are practically non existent now. Public policy forces manufacturers to

> add iodine to the salt we consume. As it contributes to the improvement of the nutritional situation, it also contributes to the prevention of chronic noncommunicable diseases. We know that the connection of nutrition to these diseases is very clear and direct.

Another initiative also mentioned by another key informant was the Carmem Project. It is a World Health Organization project which was proposed even before PNAN, in 1999. Depending on the political settings, this project performed important activities in the health context, in some moments it flourished more, in others, it remained silent.

PNAN represented an attempt to "provide a certain logic to all this, but was not able to do it entirely." There were initiatives, for example, of a project that worked for the promotion of good food habits and physical activity, including the support material for a distance training, with the engagement of technical personnel and scientists from all over Brazil.

There were also initiatives in the Ministry of Sports in terms of stimulating physical activity, but they were completely dissociated from the Ministry of Health initiatives, as remembers this other key-informant:

> in the Ministry of Sports, there was the Institute of Sports. Pelé, if I am not mistaken, was the ministry, and programs of physical activities were developed there and also activities in the Food and Nutritional guidance, which were done by the National Institute for Food and Nutrition (INAN). But there was no dialogue between the various sectors, in spite of INAN being within the Ministry of Health and the fact that the materials used by the Ministry of Sports were created by the Ministry of Health itself.

There was also, inside the Ministry of Health, according to a player, "a small coordination working with diabetes and hypertension, but it was not very stimulated. There were only three workers there and although they were a motivated group, they formed a very small one."

> According to this player, prevention and control actions of diabetes and hypertension were not governmental priorities, according to international policies for the health sector because:

> to the international eyes, we are considered poor countries, in development, in which hunger still is a problem, therefore, to prioritize health problems resulting from excess of energy, opulence and food intake is a complicate issue. For years, this small coordination was the resistance spot for the discussion of diabetes, hypertension and cancer. Today, in the government, the area is still much sectorized. We have, for instance, the National Cancer Institute (INCA) which has been performing wonderful studies, some very good level reports about cancer, including in the nutrition area.

In what concerns the creation of a Food and Nutrition Technical Area, right after the extinction of INAN, there is an emphasis on the determining work it performed on the food consumption issue. However, historically, one could say that the

> programs developed by ATAN were not that linked to the food and nutrition area as they are today. One can observe, as seen in many works by Professor Carlos Monteiro, the tendency of malnutrition resulting in obesity. The a great number of obesity cases started being noticed in very poor populations in rural and other areas, as mentioned in several researches by Professor Malaquias Batista, in Pernambuco, and by other researchers.

The areas of Hypertension, diabetes and chronic noncommunicable diseases were not seen as an articulate set of policies within the Ministry of Health. They were not thought as a result of the same health determinant factors, such as the dissemination, in the population as a whole, of healthy habits and life styles. They were punctual interventions on specific problems, one of the reasons why they did not advance in the governmental public agenda and did not bring the expected impact in these interventions.

Nevertheless, when chronic noncommunicable diseases started to appear in middle and higher classes with frequency the government started worrying about the need to promote healthy habits for the population, as for example basic health care. At that time, the obesity issue was placed in tertiary attention level and did not reach the healthy centers.

On the other hand, there was a great basic health demand in the health centers concerning malnutrition and diarrhea. More recently these health centers started to work

with hypertensive, diabetic and obese patients, including training health professionals to attend unit patients and placing doctors in these specific areas “because until then, there were no doctors for that. Health centers were more dedicated to pediatrics and general practice. There wasn’t anybody to look into chronic degenerative diseases.”

With the coming of a Global Strategy on healthy nutrition, the prevention and control of chronic noncommunicable diseases are, little by little, becoming part of the Brazilian health agenda. Before, the problem was much more restricted to the researchers dedicated to the epidemiological study of the event, “no thought was given then to the lower classes that are frequently mentioned today when one talks about obesity.” Each region of the country presented a diagnosis, as reminds us a key-informant.

It is worth highlighting that one of the first steps towards CNCD awareness took place in 1988, with a multicentric study on diabetes prevalence in Brazil. Later on, with the cooperation of the food surveillance area, within the food and nutrition area, the issue of the need for national labelling was dealt with in order to show people the amount of fat, sugar, etc.

CNCDs make up one of PNAN’s seven guidelines. Healthy food promotion has a fundamental impact on CNCD prevention and control, touching all other guidelines, reason by which its prioritization was important in the scope of the National Policy on Food and Nutrition since it brought this new concept of a concern regarding chronic noncommunicable diseases that permeates all human life time.

In this sense, this guideline enhances the fact that lifelong prevention and control concern should be incorporated to all actions and all programs of the ministry, meaning that since the birth day until elder age, it is necessary to promote healthy life actions in a way to prevent chronic noncommunicable diseases and, consequently, have a positive impact in epidemiological and nutritional indicators.

In spite of not having it necessarily written this way, the approach towards what is a food and nutritional component is a great political concern. According to a PNAN key-informant:

> particularly, I think it is necessary to promote healthy nutrition focusing not only the chronic noncommunicable disease control and prevention issue, but also our health as a whole. Something else I find essential is the physical education matter. I read articles showing that, in fact, hypertensive patients who start exercising regularly end up reducing continued use of medicine doses, while many of them even have them suspended. PNAN, in this promotion area, has a lot to contribute to.

Since year 2004, with the implementation of the Global Strategy on healthy nutrition, the Brazilian Ministry of Health has prioritized food and nutrition related to chronic noncommunicable disease prevention and control guidelines. Some of the interviewees stated that it is a political priority in the health area, particularly, in what concerns overweight and obesity problems. Brazil has approximately 3 million malnutrition victims and 40 million overweight and obese persons. These statistic data establish a health promotion agenda for the country, since they are generally connected, in public health and epidemiological terms, to diabetes, hypertension, and heart diseases (BATISTA, 2005).

Within the Ministry of Health, the Global Strategy has been conducted jointly by different areas, being coordinated by the Health Surveillance Secretariat, by means of the General Coordination of Noncommunicable Diseases and Illnesses (CGDANT) with the cooperation of the General Coordination on Food and Nutrition (CGPAN), under SAS. It also involves other technical areas of the mentioned Ministry, such as: the National Cancer Institute (INCA), ANVISA, among others.

In order to conduct the Global Strategic actions, the Ministry of Health, by means of Directive No. 1190, of 14 July 2005, implemented the Health Promotion National Policy Managing Committee, aiming at developing, strengthening and implementing policies and action plans in municipal, state and national level, consolidating health promotion component in SUS; considering health promotion a transversal articulation strategy capable of creating mechanisms to reduce vulnerability situations and

population health risks, defending equity and incorporating social participation and control into the public policy management; bearing in mind the purpose of the National Policy for Health Promotion of contributing to changing the care system model through the expanding and qualification of health promotion actions and the construction of an integrated strategic agenda. It would also consider the guidelines of the National Policy on Health Promotion based on integrality, equity, health responsibility, mobilization, social participation, intersectoriality, information, education and communication and sustainability.

The duties of the referred Management Committee are the following:

I. to consolidate the proposal of the National Policy on Health Promotion;
II. to consolidate Health Promotion National Agenda 2005–2007 according to the policies, priorities and resources of each secretariat of the Ministry of Health and to the National Health Plan;
III. to articulate and integrate health promotion actions within SUS;
IV. to coordinate the implementation of the National Policy on Health Promotion in the SUS and throughout its articulations with governmental and non-governmental sectors;
V. to stimulate states, municipalities and the Federal District to elaborate Health Promotion Plans, considering the guidelines on the National Policy on Health Promotion and the Health Promotion National Agenda;
VI. to monitor and evaluate the implementation of the National Policy on Health Promotion and its impact in improving individual and collective life quality.

CGPNPS will be formed as follows:

I. three delegates from the Health Surveillance Secretariat / SVS;
II. three delegates from the Health Care Secretariat / SAS;
III. one delegate from the Participatory Management Secretariat / SGP;

IV. one delegate from the Labor and Health Education Management Secretariat / SGTES;

V. one delegate from the Science, Technology and Strategic Supplies / SCTIE;

VI. one delegate from the National Health Foundation / FUNASA;

VII. one delegate from Oswaldo Cruz Foundation / FIOCRUZ;

VIII. one delegate from the National Health Surveillance Agency / ANVISA;

IX. one delegate from the Supplementary Health Agency / ANS;

X. one delegate from the National Cancer Institute / INCA.

§ 1- Each nominal member of the Health Promotion National Policy Management Committee will point out a substitute delegate.

§ 2- CGPNPS nominal and substitute members will be appointed by directive of the Health Surveillance Secretariat.

§ 3- Members must declare the nonexistence of conflict of interests with their activities in what concerns the topics discussed by the Committee, whereas, in the event of a conflict of interest, they shall refrain to take part in the discussion and decision on the topic.

CGPNPS will have an Executive Secretariat, linked to the Health Surveillance Secretariat, responsible for its coordination.

It is of the Health Surveillance Secretariat competence to adopt measures and procedures necessary for the full functioning and effectiveness of what is established by this directive.

In order to proceed with the actions resulting from the Brazilian adhesion to the Global Strategy, in 2005, a new Ministry of Health Directive No. 2.608/GM of 28 December 2005, defined the financial resources from the Health Surveillance financial ceiling, to stimulate the structuring of Noncommunicable Diseases and Illnesses Prevention and Surveillance actions by State and Municipal Secretaries (Capital, specifically). This is, therefore, a very important tool in the sense that it develops public

noncommunicable diseases and illnesses surveillance and prevention policies, reducing their risk factors related to sedentarism, inadequate food intake and tabagism, according to the Nutritional and Physical Activity Global Strategy / GS and the Tobacco Control Scale, proposed by the World Health Organization (WHO).

8. Conclusions

The construction of PNAN was based on the indication of important issues concerning the Brazilian food and nutritional profile, having as basis the assumptions presented in the World Food Summit.

At the time PNAN was formulated, the regulation milestone on food production, stocking and labelling, food production subsidies and advertisement control in the media were incipient. With the event of Globalization, Brazilians have, more and more, followed the Western diet habits, making it difficult for the Ministry of Health to focus on a broader policy then the one of malnutrition.

The guarantee of food security and quality is a challenge still present and acquiring greater proportions in PNAN. The promotion of healthy nutritional practices, the promotion and right to food access and this guideline operation implies a governmental line of action that goes beyond the health sector. This intersectoriality is present in the moment one tries to insert the food industry in the implementation of measures related to the enrichment and/or correction of foodstuff as, for example, in the obligation of adding iodine to the salt produced for populational consumption.

PNAN creation was based on constitutional principles—food as human right and governmental duty, and guaranteed in the legal text (Directive No. 710, of 11 July 1999), However, the directive by itself does not guarantee the effectiveness of the actions. Food, as a human right, requires an intersectorial effort. It is also necessary that there will be a terminology pact, to acquire minimum knowledge of causality processes and

determinant factors concerning CNCDs, i.e., generation of quality data to evaluate the policies and the causality networks of public health problems—today's greatest challenge.

A significant advance was the inclusion of the topic in the agenda, in the sense of creating a public policy in the food and nutritional area, with a regulation milestone (the Ministry directive) and with the population's awareness of CNCD prevention. This would be one of PNAN guidelines (healthy nutrition and physical activity), besides food labelling need, obesity related educational TV programs, among other actions.

It is important to highlight that PNAN, considered by one of the key-players as "advanced and modern", was taken over as a governmental policy, including in regards to the execution of its guidelines as was the case of the food scholarship (2002-2003) and family scholarship (2004 until today).

It can be recorded as PNAN's merit, the implementation of SISVAN, as a result of one of its guidelines, directed to the gathering of information to subsidize public policies to improve the population nutritional conditions and to maintain a sectorial convergence point in the public health sector.

The policy creation took place in a very participative manner, not by chance, in the human resources area. Professionals in the food and nutrition area consider the policy a regulatory mark, in the political, technical and ethical spheres, an strategy of action to carry out its guidelines, starting a great training process of managers in all governmental spheres towards the implementation of PNAN's actions.

Food and Nutrition and Surveillance teams concerning CNCDs must work in a joint manner, in a single coordination, bearing in mind the implementation of the Global Strategy. Finally it must work so that the priority of the Ministry of Health, in terms of policies and strategies, may benefit health promotion since its efficiency will diminish the hospital-medical care demands and improve laws regulating health surveillance, even if

there has already been a great advance in this field, in the past years (in sanitation surveillance, for instance).

9. Lessons Learned with the PNAN Creation Process: Brazilian Case Study

Some issues that deserve consideration, which are important not only for the creation of PNAN, but for other policies, are mentioned below.

In opposition to many recurring thoughts, the food and nutrition issue has always been in the Brazilian public agenda, although the priority given or the ability to deal with its complexity changed from government to government.

The simultaneous processes of creation and implementation of public policies proved to be a solid learning, based on the search for democratic improvement: *"The process of creation of PNAN was very inclusive, consultive, at the same time we tried to recognize the programs, extinguishing some actions and improving others"*, what resulted in a process of citizen partnership, making it possible to expand the discussion to the civil society.

It became clear, from the lessons learned in the PNAN creation process and during the implementation of its actions (1999-2005), the influence of international organizations in the creation and financing of the Brazilian programs and policies, as well as their influence in the values, ideas and knowledge fields in the health professional area itself (doctors, nutritionists, nurses)

PNAN's creation process was the trigger to other health policies, in the Ministry of Health. It is important to enhance the fact that its creation and approval happened in a context of governmental crisis, from which food and nutrition specialist and active supporters took advantage to make strategic changes in the area, facing the crisis as an

opportunity window in the sense used by Kingdon (1995). From this perspective, the possibility to institutionalize the proposal by the Ministry of Health become clear —a regulatory and normative milestone allowing the Policy development, the possibility of articulating the definition of the problem, with the solution alternatives and the political priorities of the public managers—to decision makers, the possibility to analyze the relation between the existing forces in a certain scenario and the margin of freedom public managers have in the field of ideas and action proposals and the possibility of adding public value to the process of creating and managing public policies—participatory dimension: State and civil society.

10. Bibliography

ABRANCHES, Sérgio Henrique, SANTOS, Wanderley Guilherme, COIMBRA, Marcos. **Política social e combate à pobreza** (3 ed.). Rio de Janeiro: Zahar, 1994.

ABRANCHES, Sérgio Henrique. **Os despossuídos: crescimento e pobreza no país do milagre** (2 ed.). Rio de Janeiro: Zahar, 1986.

ALVES-MAZZOTTI, Alda Judith, GEWANDSJNAJDER, Fernando. **O método nas ciências naturais e sociais—pesquisa quantitativa e qualitativa**. São Paulo: Pioneira, 1998.

ANGUS, D. et Al. **Sustainable Health Care for Canada**, Ottawa: Universidade de Ottawa, 1995.

ARRETCHE, Marta T. S. "Tendências no estudo sobre avaliação" In: **Avaliação de políticas sociais: uma questão em debate**. São Paulo: Cortez/IEE, 2001.

ASHLEY, M.J. et al. "How Canadian Legislators View Health Promotion: Does Party Affiliation Matter?" **Canadian Journal of Public Health**, Vol. 92, No.1, 2001. pp 16-18.

ATKINSON, M.M. and COLEMAN, W.D. (1992) **Policy Networks, Policy Communities and the Problems of Governance**, 5, 154-180.

BARDACH, Eugene (1998); **Getting Agencies to Work Together. The Practices and Theory of Managerial Craftsmanchip.** Washington: The Brookings Institution.

BARDACH, Eugene (2000); **A Practical Guide for Policy Analysis. The Eightfold Path to More Effective Problem Solving**. New York: Chatham House.

BARZELAY, M.; Gaetani, F.; Cortazar, J. C. y Cejudo, G. (2002); "Investigación sobre reformas a las políticas de gestión pública en América Latina. Marco conceptual, **Guía metodológica y estudio de caso"**. Washington D.C.: BID.

BATISTA FILHO, Malaquias, BARBOSA, N.P. **Alimentação e Nutrição no Brasil, 1974-1984**. Brasília: INAN, Ministério da Saúde, 1985.

BATISTA FILHO, Malaquias, Barbosa. SISVAN: breve história, grandes perspectivas. In **Boletim SISVAN**, available at dtr2004.saude.gov.br/nutricao/boletim_sisvan. Acess on March 23rd 2006, at 11h25.

BATISTA FILHO, Malaquias, Interview given to this researh on November 2005.

BRASIL. PRESIDÊNCIA DA REPÚBLICA Law 5.929, 30 de novembro de 1972 (Criação do INAN).

BRASIL. PRESIDÊNCIA DA REPÚBLICA Decree 73.996 de 30 de abril de 1973 (INAN, Autarquia).

BRASIL. INSTITUTO NACIONAL DE ALIMENTAÇÃO E NUTRIÇÃO. **Programa Nacional de Alimentação e Nutrição — PRONAN: 1976--1979.** Brasília, 1976. (Documento Técnico INAN — 6/76).

BRASIL. MINISTÉRIO DA SAÚDE. **Histórico do Incentivo ao Combate ás Carências Nutricionais. Secretaria de Assistência à Saúde**, Departamento de Atenção Básica, CGPAN, 1998.

BRASIL. MINISTÉRIO DA SAÚDE. Prevenção e Controle das Doenças Não Transmissíveis no Brasil. Série B. **Textos Básicos de Saúde**. Brasília: 2002.

BRASIL, MINISTÉRIO DO PLANEJAMENTO. **Relatório de Avaliação do PPA, 2002**. www.planejamento.gov.br.

BRASIL. MINISTÉRIO DA SAÚDE. Política Nacional de Alimentação e Nutrição. Série B. **Textos Básicos de Saúde**. 2ª edição revista. Brasília: 2003.

BRASIL. CONSEA**, II Conferência Nacional de Segurança Alimentar e Nutricional:** A construção da Política Nacional de Segurança Alimentar e Nutricional. Relatório Final, Brasília, 2004. Available at http://www.presidencia.gov.br/consea/static/documentos/IIConferencia.pdf.

BRASIL. FUNASA/MINISTÈRIO DA SAÚDE. **Proposta de Monitoramento dos Agravos Não Transmissíveis e seus Fatores de Risco.** II Reunião para Implantar o Monitoramento de Doenças Não Transmissíveis, de seus Fatores de Risco e de outros Agravos à Saúde.

BRASIL. MINISTÉRIO DA SAÚDE, OPAS. **Avaliação do Plano de Reorganização da Atenção à Hipertensão Arterial e ao Diabetes Mellitus no Brasil**. Brasília-DF, 2004.

BRASIL. MINISTÉRIO DA SAÚDE. **Análise da Estratégia Global da OMS para Alimentação Saudável, Atividade Física e Saúde**. Brasília: 2004.

BRASIL. MINISTÉRIO DA SAÚDE. **Estudo de Caso Brasil: a integração das ações de alimentação e nutrição nos planos de desenvolvimento nacional para o alcance das metas do milênio no contexto do direito humano à alimentação adequada.** Ministério da Saúde, Secretaria de Apoio de Atenção à Saúde, Departamento de Atenção Básica. Coordenação-Geral da Política de Alimentação e Nutrição, Brasília: Ministério da Saúde, 2005.

BRASIL. MINISTÉRIO DA SAÚDE. Estrutura e competencias da Anvisa. www. Anvisa.gov.br. Access on May 21st,2006.

BROWNSON RC, RemingtonPL, Davis J. **Chronic Disease Epidemiology and Control**. American Public Health Association. Baltimore, MD, 1993.

BUSS, Paulo Marchiori. **Promoção da Saúde no Brasil. Conferência apresentada ao I Seminário Brasileiro de Efetividade da Promoção da Saúde**. Rio de Janeiro, 10 de maio de 2005. Available at http://www.abrasco.org.br/GTs/GT. Access on March 3rd, 2006, at 14:59.

CASTRO, Jorge Abrahão de. **Avaliação do processo de gasto público do Fundo Nacional de Desenvolvimento da Educação (FNDE)**. Rio de Janeiro: IPEA, 2000. (Texto para discussão, 760).

CASTRO, JOSUÉ. **Geografia da Fome**. Rio de Janeiro: Cruzeiro, 1946.

CLOTTEY, Clarence. **Estrutura e metodologia para analisar iniciativas de formulação de políticas integradas relativas á prevenção de doenças crônicas**. Centro Colaborador da OMS sobre políticas integradas relativas á prevenção de doenças crônicas. Canadá, 2005.

COHEN, J.E. et al. "**Predictors of Canadian Legislators Support for Tobacco Control Policies," Social Science and Medicine**, Vol. 55. 2002, pp. 1069-1076.

CORTAZAR, Juan Carlos y Lecaros, Carla, (2003) **La Viabilidad de las prácticas de participación ciudadana. El caso del presupuesto participativo de Villa El Salvador***, (Perú, 2000–2002),* Washington, INDES-BID, 2003.

CRUSIUS, Yeda et al. **Plano de Combate à Fome e à Miséria—Princípios, Prioridades e Mapa das Ações do Governo**. Brasília: IPEA, abril de 1993.

DEMO, Pedro. Globalização da exclusão social - contradições teóricas e metodológicas do discurso neoliberal acerca do enfrentamento da pobreza. **Ser Social, 4**, 43-44, 1999.

DESVEAUX, J.A. et al (1994), "Organizing for Policy Innovation in Public Bureaucracy: AIDS, Energy and Environmental Policy in Canada," **Canadian Journal of Political Science**, XXVII: 3, pp. 493-528.

DINIZ, Amélia Franco. **A Política de Alimentação e Nutrição na Nova República: ilusões e desencantos no contexto do descaso**. Dissertação em Serviço Social. Universidade de Brasília, 1988. 50 páginas.

DRAIBE, Sônia (2001) Avaliação de implementação: esboço de uma metodologia de trabalho em políticas públicas. In: Barreira e Carvalho (Orgs.) **Tendências e perspectivas na avaliação de políticas e programas sociais.** São Paulo: IEE/PUC-SP, pp.13-42.

EDUARDO, Maria Bernadete de Paula; MIRANDA, Isaura Cristina Soares. Coleção Instituto para o Desenvolvimento da Saúde (IDS); Núcleo de Assistência Médico-Hospitalar (Namh/FSP/USP); **Banco Itaú: Série Saúde e Cidadania, vol 8,** São Paulo: 1998. Available at: http://bases.bireme.br/bvs/sp/P/pdf/saudcid/Volume08.pdf. Access on March 27, 2006, at 16h01.

ESCODA, Maria do Socorro Quirino. **Investimento no capital humano: Uma análise da política de nutrição, RN;** Projeto Rio Grande do Norte; CNPq/FUNPEC, ano II, nº 2 e 3, 05/1983. < http://www.ufrnet.br/~scorpius/37-Inv%20Cap %20Hum.htm>.

ESCODA, Maria do Socorro Quirino; VILAR, Maria Helena; BEGIN Natalie. Política Nacional de Alimentação e Nutrição**. IX Conferencia Nacional de Saúde**. Painel. Ministério da Saúde. UnB, Brasília,1992. Disponível em http://www.ufrnet.br/~scorpius/37Inv%20Cap%20Hum.htm

EVANS, R.G. and STODDART, G.L. Producing Health, Consuming Health Care, in Evans, R.G., Barer, M.L. and Mannor, T.R., eds., **Why Some People are Healthy and Others Are Not**, New York: Aldine De Gruyter, 1994,4-27.

FÓRUM BRASILEIRO DE SEGURANÇA ALIMENTAR E NUTRICIONAL**. A trajetória do Fórum Brasileiro de Segurança Alimentar e Nutricional (FBSAN).** www.fbsan.org.br, 2003.

FOLHA DE SÃO PAULO. "Bolsa Família tem foco, mas não emprega". São Paulo. **Folha de São Paulo, Edição de 28 de maio de 2006,** p.A23.

_____. "Integrar programas será a prioridade do ministério". São Paulo. **Folha de São Paulo, Edição de 28 de maio de 2006,** p.A24.

_____. "Programas de Transferência de Renda". São Paulo. **Folha de São Paulo, Edição de 28 de maio de 2006,** p.A24.

FUCHS, Werner Pastor; PASSOS, Zélia. **A Mobilização pela Segurança Alimentar e Nutricional Sustentável no Paraná**. Available at http://www.setp.pr.gov.br/setp/conselhos/consea/. Access on March 27th, 2006, at 17h40.

GERSCHMAN, Silvia. Sobre a formulação de políticas sociais. In: **Reforma Sanitária: em busca de uma teoria.** São Paulo: Cortez/ABRASCO, 1989.

IPEA. **A Segurança Alimentar e Nutricional e o Direito Humano à Alimentação no Brasil**. Brasília, 2002.

IPEA. "Segurança Alimentar e Nutricional no Brasil". **Cadernos Comunidade Solidária**, v.2, nov.1996, Brasília, IPEA, 1996.

KINGDON, John W. **Agendas, alternatives and public policies***.* New York: Longman, 1995.

LAGE, Otaviano. **Seis Anos de trabalho pela Cidadania**. In: .http://www.consea.mg.gov.br/documentos/seis_anos_trabalho_pela_cidadania.pdf. Acesso em 05.04.06, às 18h35.

LAVIS, J. et al (2001), **"Barriers to Employment -related Healthy Public Policy in Canada**," Health Promotion International, Vo1.16, pp. 9-20.

LESSA, Inês. "Os programas nacionais de educação e controle para DCNT" In LESSA, Inês (org) **Adulto brasileiro e as doenças da modernidade. Epidemiologia das doenças crônicas não-transmissíveis no Brasil.** SP: Hucitec, 1998.

LESSA, Inês. Doenças crônicas não-transmissíveis no Brasil: um desafio para a complexa tarefa de vigilância. **Ciência & Saúde Coletiva, vol. 9, nº 4**, Rio de Janeiro Out/Dez 2004.

MAJONE, Giandomenico. **Evidencia, argumentación y persuasión en la formulación de políticas.** México: Fondo de Cultura Económica, 1997.

MALUF, R. S., MENEZES, F., VALENTE, F. L. Contribuição ao tema da Segurança Alimentar no Brasil. Vol. IV. **Revista Cadernos de Debate**, Núcleo de Estudos e Pesquisas em Alimentação da UNICAMP; 1996.

MCKAY, L. **Making ofthe Lalonde Report,** CPRN Research Report, 2001.

MERRIEN, François Xavier. **L´Etat Providence**. Paris: PUF, 2000.

MINAYO, Maria Cecíliade Souza. **O desafio do conhecimento—pesquisa qualitativa em saúde.** São Paulo-Rio de janeiro: Hucitec-Abrasco, 1996.

MOISÉS Kátia Cilene Machado de Souza. **Implantação da Vigilância Nutricional no Estado do Rio Grande do Norte.** Monografia apresentada em cumprimento ao requisito final para obtenção do grau de especialista do curso de Especialização em Vigilância Sanitária de Alimentos do Departamento de Nutrição da UFRN. NATAL/RN 2001

MULLER Pierre, SUREL Yves, **L'analyse des politiques publiques**, Paris, Montchrestien, coll. Clefs politique, 1998.

NÉRI, M. Dois anos de política social. IBRE/FGV; **Conjuntura Econômica**; Fevereiro de 2005.

OFFE, Clauss. **Problemas estruturais do estado capitalista**. Rio de Janeiro: Tempo Universitário, 1984.

OPAS, **Observatorio de Políticas para la Prevención de Enfermedades no Transmisibles en Latinoamerica y el Caribe**. División de Prevención y Control de Enfermedades. Programa de Enfermedades no Transmisibles. Washington, Diciembre, 2002.

PAGNUSSAT, José Luiz. **Curso PPA: elaboração do plano e gestão de programas**. Brasília, ENAP, 2003. Available at www.enap.gov.br.

PEREIRA, Potyara Amazoneida Pereira. & PAIVA, Leda Del Caro. A política social e a questão da pobreza no Brasil. **Serviço Social & Sociedade, 5**, 1981, pp. 1-13.

PEREIRA, Potyara Amazoneida Pereira. Centralização e exclusão social: duplo entrave à política de assistência social. **Ser Social, 3**, I 19- I 34, 1998.

PEREIRA, Rosana Sperandio. **Participação da Sociedade Civil no Governo Itamar Franco: Conselho Nacional de Segurança Alimentar (CONSEA)**. Universidade de Brasília: Dissertação de mestrado em Política Social. Brasília, 1997.

RODRIGUES, M. T. **A Participação no Sistema Único de Saúde: Controle Social e Democratização**. In: Tese de Mestrado; Departamento de Serviço Social; Universidade de Brasília; Brasília; 1995.

ROTHSTEIN, B. (1998) Political Institutions: An Overview, in Goodin, R.E. and Klingemann, eds., H-D. A New Handbook of Political Science, Nova York: Oxford University Press, 133-166.

RUIZ, M. **A história do Plano Collor**. Available at <http://www.sociedadedigital.com.br/artigo. php.artigo=114&item=4> Published on October 16th, 2003.

SANTOS, Wanderley Guilherme. **Cidadania e justiça: a política social na ordem Brasileira** (10 ed.). Rio de Janeiro: Campos, 1979.

SILVA, Maria Ozanria da Silva et al. Comunidade Solidária: contradições e debilidades do discurso. In: SILVA, Maria ozanria (Coord.) **O Comunidade Solidária: o não enfrentamento da pobreza no Brasil.** São Paulo: Cortez, 2001, pp.71-92.

SILVA, Maria Ozanria da Silva et al. A focalização fragmentadora e a insuficiência do Comunidade Solidária no enfrentamento da pobreza: estudo de um caso do Nordeste.In: SILVA, Maria ozanria (Coord.) **O Comunidade Solidária: o não enfrentamento da pobreza no Brasil.** São Paulo: Cortez, 2001, pp. 143-144.

SILVA, Alberto Carvalho da. **De Vargas a Itamar: políticas e programas de alimentação e nutrição**. *Estud. av.* [online]. Apr. 1995, vol.9, no.23 [cited 15 February 2006], p.87-107. <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S010301419950001000007&lng=en&nrm=iso>. ISSN 0103-4014, Access on January 20th, 2006.

SUBIRATS, Joan; (1989) **Análisis de Políticas Públicas y Eficacia de la Administración**, Madrid, INAP.

USP. **Um país em construção**. Available at <http://www.bibvirt.futuro.usp.br/textos/humanas/historia/tc2000/h39b.pdf>. Access on: March 7th, 2006.

VALENTE, Flávio Luiz Schieck. **A política de insegurança alimentar e nutricional no Brasil de 1995 a 2002.** Publicação Eletrônica; 2005. Available at <http://www.fomezero.gov.br/download/pol_inseg_alimentar_Flavio_Valente.pdf Flávio Valente>

_____ A Evolução, Conceito e o Quadro da Segurança Alimentar dos anos 90 no Mundo e no Brasil. Publicação Eletrônica; 2005. Disponível em: <agora@agora.org.br>.

_____ O combate à fome e à desnutrição e a promoção da alimentação adequada no contexto do Direito Humano à Alimentação: um eixo estratégico do desenvolvimento humano sustentável", 2001, mimeo.

_____ A Cesta Básica como Complemento Alimentar, Nutricional e de Renda. Publicação Eletrônica; 2005. Available at: <agora@agora.org.br>.

VASCONCELOS, A. G. V. **Combate à fome no Brasil: uma análise histórica de Vargas a Lula.** Revista de Nutrição vol. 18, nº 4; Campinas; Julho/Agosto de 2005**.**

VOGEL, Ellen. **Ferramenta para Relatórios e Análise de Conjunto de Casos**. Observatório de Políticas relativas a DCNT. Montreal, Canadá, 2005.,

WELLER, G.R.I The Determinants of Canadian Health Policy" **Journal of Health Politics, Policy and Law**, Vol. 5, No. 3, 1980, pp. 405-418.

YIN, R. K. (1994); **Case Study Research. Design and Methods**. Second Editions. Thousand Oaks: SAGE.

11. Annexes

Annex 1: National Policy on Food and Nutrition / PNAN (Summary)

Public Health Magazine
Print ISSN 0034-8910

Rev. Saúde Pública vol.34 n.1 São Paulo Feb. 2000

Informes Técnicos Institucionais ***Technical Institutional Reports***

Health Sector, National Policy on Food and Nutrition,Health Policies Secretariat

In 1999, the Ministry of Health implemented a series of essencial measures for the sector, described in the National Policy on Food and Nutrition—PNAN—formally approved by Directive 710, published by the Brazilian Official Press, last June. This National Policy formulation was coordinated by the Health Policies Secretariat—also responsible for its implementation—with the participation of different governmental sectors, society layers and experts in the topic, having been submitted to the appreciation of the Tripartite Intermanagers Commission and of the National Health Council.

The adoption of thiis Policy is a very important milestone since food and nutrition are basic requirements for health promotion and protection. In the context of food and nutrition, Brazil deals with extreme situations: on one hand, malnutrition and the deficiency of some essential micronutrient are still prevalent, while on the other hand, there are growing and high obesity rates. This National Policy is present in the context of food and nutritional security and has as purpose to guarantee the quality of food consumed in Brazil, to promote healthy nutritional practices and to prevent and control nutritional disturbs, as well as to take the incentive to intersectorial actions that provide universal access to food.

The food security concept that was previously limited to the supply, in the appropriate quantity, was also expanded, by incorporating universal access to food, the nutritional aspect and, consequently, the issues concerning composition, quality and biological benefits. Brazil adopted this new concept in 1986, with the First National Food and Nutrition Conference, having it consolidated as from the

National Food Security Conference, in 1994.

Agricultural credit, adoption of industrial and agricultural technologies, strategic stocks, cooperativism, importation, distribution, food storage and conservation, sustainable handling of natural resources, etc. are part of the components of food and nutritional security. Therefore, the actions to guarantee this security go beyond the health sector, reaching an intersectorial character, above all in what respects production and consumption, which includes the population buying power and the choice of foods to be consumed, including the cultural factors interfering in such a selection.

Both the security concept adoption, in the world level, and the resume of discussions on the topic by the Brazilian government, made it easier to understand the health sector role in what concerns food and nutrition. In the context of food and nutritional security, it is marked by two moments that can be called, respectively, positive and critical.

The positive moment happens when food offer, distribution and consumption, made possible by extra-sectorial means and with society participation, happens normally, in terms of quantity, quality and regularity, as well as in terms of the biological use. In these positive conditions, the predominant actions of the health sector are food and nutritional surveillance, food health surveillance and educational measures.

The critical moment happens when there are gaps in the offer, consumption or in food biological use standard. In these circumstances, extra-sectorial obstacles (income deficiency, interruption of production, variation in the supply) or sectorial, for instance, lack of information and inappropriate food habits, as well as the presence of endemic diseases or injuries may lead to the existence of health problems. The solution for these problems is a competence of the health sector: malnutrition, specific deficiencies, obesity, diabetes mellitus, dislipidemies and association to other chronic diseases of recognized epidemiological relevance.

Guidelines

In order to reach PNAN's purposal, seven essential guidelines have been established: incentive to intersectorial actions aiming at universal access to food; guarantee of food security and quality and of related service provision, monitoring of food and nutritional situation, healthy food habits and life style, prevention and control of nutritional disturbs and food and nutritional related diseases, promotion of investigation lines development promotion, and development and qualification of human resources.

In what concerns the incentive to **intersectorial actions aiming at universal access to food**, the Policy establishes that the health sector, as bearer of epidemiological data related to favorable and unfavorable food and nutritional

aspects, shall promote great articulation with other governmental sectors, civil society and the productive sector, which action is connected to determinant factors that interfere in the universal access to good quality food.

The basic strategies to **guarantee the security and quality of food related products and services** will be to redirect and strengthen the health surveillance actions. Such actions are particularly important when thinking about the constant renewal of production technologies, industrial processing, conservation, packaging and other aspects forming the population food supply and consumption.

In terms of the Health Surveillance National System, the operational and technical rules concerning food and food related services shall be reviewed, emphasizing those related to the prevention of health damages. Fiscalization tools shall be modernized by adopting production and service provision control and security measures, bearing in mind, especially, risk analysis and critical point control, aiming at preventing diseases transmitted by food and economic losses due to deterioration.

Besides this, rationalization, coordination and control of the health surveillance processes in all segments of the food chain, since the production phase through labelling, storage, transport, trade, until the consumption stage. The updating of the national health legislation on food, considering biotechnology advances—processes of transgenicity and others—as well as the compatibilization of surveillance procedures and criteria, according to legal tools guiding the international agreements will be promoted.

For the **monitoring of the food and nutritional situation**, the Food and Nutritional Surveillance System SISVAN must be expanded and improved, speeding up its procedures and expanding its coverage to the whole country. SISVAN's action will comprehend the continuous description and the anticipation of the tendencies on food and nutritional conditions of the population, as well as their determinant factors. The descriptive and analytic diagnosis of the problems and main determinant factors must characterize major risk geographic areas, social layers and biological groups.

During this monitoring, Sisvan must prioritize pregnant women and children growth and development, serving as the basis for all work in the service network, especially in what concerns basic health care. There will also be an attempt to incorporate the nutritional situation of each user to the service routines, aiming to detect the risk situation and the prescription of actions that may facilitate the prevention of its effects and the guarantee to reverse the picture to a normality status.

Other priority must be the mapping of endemic deficiencies, in a way to show their spatial distribution and to indicate the magnitude of the Energetic Proteic

Malnutrition / EPM, anemia, hypovitaminosis A and iodine deficiency. In terms of chronic noncommunicable diseases, related with nutrition and life styles considered inappropriate, the work must be made compatible to the working systems in terms of data collection, production, flow, processing and analysis.

In a more specific manner, information systems will focus on aspects connected to breastfeeding practices and the positive or negative interference factors, as well as on periodic evaluations of public school students' nutritional situation. Food production and the critical analysis of its qualitative and quantitative offer and consumption will also be essential monitoring points.

On its turn, the **healthy nutritional practices** guideline is inserted in the context of adoption of a healthy life style, important component of health promotion. Food and Nutrition knowledge sharing will be emphasized, as well as the prevention of nutritional problems, from malnutrition including specific deficiencies to obesity. The actions directed towards the adoption of healthy nutritional practices shall integrate all measures resulting from the guidelines defined by the National Policy.

The resuming of regional nutritional habits and practices related to the intake of low cost and high nutritional value local food products shall be focused as a priority. The same shall happen to more varied nutritional patterns, from the first years of life until adulthood and old age. Besides this, particular emphasis shall also be given to chronic noncommunicable diseases, such as heart diseases and diabetes mellitus, and to the adoption of appropriate healthy nutritional habits by their carriers, as a way to avoid the worsening of these pathologies.

The review of action methods and strategies will be the basic and initial measure to turn effective the priority given to breastfeeding incentive, especially through the articulation with different social segments, mainly those with greater capacity to influence breastfeeding practices. The adoption of measures directed at creating rules for the advertising of food products directed at children will also be very important. In parallel, from the criteria previously established, institutional programs, such as "Children Friendly Hospital" and the Mother Milk Banks, will also be supported, as well as movements directed at stimulating breastfeeding, initiated by non-governmental organizations. The milk banks will receive special attention, in order to strengthen their activities and effectively incorporate them to healthy service routines.

In what concerns the legislation, directives securing basic conditions to allow mothers to breastfeed their children, such as work hours and a work place compatible to the breastfeeding practices, shall be reinforced, expanded and made public, as well as the follow up of the industrialization and commercialization process of pharmaceutical or diet product, presented as therapeutic or prophylactic solutions to nutritional problems (weight control, fatigue, aging

process, prevention and treatment of diseases difficult to handle).

The implementation of the guideline related to the **prevention and control of nutritional disturbs and food and nutritional related diseases** will involve an action based on two polar situations, bearing in mind the inexistence of a clear division among nutrition specific institutional measures and health conventional interventions. In the first situation, a picture of morbid-mortality prevails, dominated by the words malnutrition/infection that affects mainly the poor children, particularly in socially and economically underdeveloped regions. In the second situation, there is a predominant group of overweight and obesity, diabetes mellitus, heart diseases and some neoplasic infirmities.

In the group of chronic noncommunicable diseases, the measures will be directed towards health promotion and the control of food and nutritional deviations since they form the most effective conducts to prevent their establishment and evolution. Food and nutritional problems gravitating around proteic-energetic malnutrition will be focused by means of a family approach, recognizing that the risk factors are defined in a context that could be called “vulnerable family”.

As to malnutrition/infection, the emphasis shall be placed in actions directed to the prevention and appropriate handling of infectious diseases. Food distribution and nutritional education will be indispensable means, associated to diarrhea, acute respiratory infections and immune-avoidable diseases, essential to avoid malnutrition or its worsening.

Growth and development surveillance will be adopted as the support basis to all children health care activities, especially of those with low birth weight, due to the great level of vulnerability to malnutrition and infectious diseases. Children at risk of malnutrition, from six to 23 months of age, will receive nutritional assistance, control of coexisting diseases, and surveillance of siblings or contact persons, including pregnant women and breastfeeding women in nutritional risk, with emphasis to the poverty belts.

Nutritional situation monitoring, fundamental to PEM prevention and control, will be incorporated to the assistance routines in general, in a way to cover the whole risk age, as well as to facilitate the identification and development of actions directed to: the reduction of moderate and acute infant malnutrition, anemia and malnutrition in pregnant women and of low birth weight occurrences and the follow-up of those cases.

In respect of micronutrient deficiencies and specifically the control of iron deficiency, essential measures such as nutritional enrichment, educational guidance and the use of iron supplement will be adopted as essential measures. For the reduction of anemia due to iron deficiency will be implemented actions to fortificate part of the Brazilian wheat and corn flour production, which are low cost and largely consumed food products. These actions aim to reduce iron deficiency anemia

in pre-school children in up to one third until the year 2003, having in mind the protocol already signed by the Brazilian government and the productive sector.

In the fighting against hypovitaminosis A, in areas known as risk areas, besides the periodic and emergency application of mega doses of retinol, the incentive to produce and consume food products rich in this type of vitamin must also be promoted. When necessary, there must also be the process of fortification of some types of food. In these risk areas, besides the other cautions inherent to the basic health care, will be given massive doses of this particular nutrient to children up to five years of age. Milk and food dough enrichment with Vitamin A, iron, or eventually other nutrients, must also be promoted.

Considering the epidemiological importance of these nutrients' deficiency, the complementation of the chemical-nutritional composition tables of the main types of food consumed in Brazil shall be performed, enhancing the contents and the availability of iron and vitamin A precursors.

It is necessary to face disturbs resulting from primary iodine deficiency by adding iodine to the salt for domestic and animal consumption, guaranteeing legal, administrative, and operational conditions to the systematic enforcement of this measure. There will be continuous control measures, not only in the iodine addition process itself, but also in the fiscalization actions of the products put in the market for consumption.

On the other hand, the breastfeeding incentive will have strategic importance to prevent proteic-energetic malnutrition, anemia and vitamin A deficiency, during the first months of life and to reduce the incidence, duration and severity of diarrheas and acute respiratory infections. The efforts directed at expanding the breastfeeding period, in a way that exclusive breastfeeding reaches the child's age of six months and that breastfeeding, combined with the introduction of appropriate food, reaches the second year of the child's life, shall be consolidated.

One of the mechanisms to guarantee the executions of these actions will be the transferring of specific federal financial resources to the area of nutritional deficiencies and other disturbs. Municipalities qualified to perform management activities as established by the Basic Operational Rule—Basic Care Full Management and Municipal System Full Management—will be able to register to receive a financial incentive linked to the Basic Care Minimum Level (PAB). The resources will be transferred, in a regular and automatic manner, from the National Health Fund to the Municipal Health Fund. It is important to stress that, according to the directive concerning the financial incentive intended to cover the costs of food and nutritional related measures, all actions to be performed are listed, among which there are those inherent to the malnutrition control in groups

of risk.

The implementation of all guidelines of the National Policy on Food and Nutrition will be supported by **investigation lines** that will clarify specific and general aspects of certain problems, evaluate the contribution of cause factors involved and point out the most suitable measures for its control. Among the lines of interest, the issue of proteic-energetic malnutrition, that in spite of having been well described and analyzed in geographical and social terms, shall receive special attention in terms of expanding the still limited knowledge about anemia and hypovitaminosis A epidemiology.

In parallel, the still preliminary studies about the relation between chronic noncommunicable diseases and diet profile shall be, in the same way, expanded and have their conclusions made public. As to the relation between food consumption and diet value, it will be subject of study which will allow the expansion of the situation analysis, once the available data refer only to some metropolitan areas.

Studies and investigations shall make possible the elaboration of national tables on the composition and nutritional value of foods and of their main cooking preparation. These tables shall consider especially the availability of iron and vitamin A. Emphays will also be given to the establishment of regional nutritional patterns to all ages, according to the prevailing local habits, including the period of transition from breastfeeding to feeding, bearing in mind the projects already started on this particular field.

Human resources training and development is a guideline that will touch all other guidelines defined by the National Policy on Food and Nutrition, as a privileged mechanism for intersectorial articulation, making it possible for the health sector to count with personnel in terms of quantity and quality. The joint work carried out with the Ministry of Education, specifically, will be made possible thanks to the indispensable adaptation of the health sector training courses, considering all the aspects inherent to PNAN guidelines.

Especially, regarding the action execution area, the training will aim at preparing human resources to perform a basic set of activities, including: case analysis, beneficiary election and the follow-up in local health services, and adequate prevention and handling of diseases which interfere in the nutritional situation or, from another perspective, in food and nutritional conditions acting as relevant factors to disease development risk, in particular chronic noncommunicable diseases.

Personnel training to plan, coordinate and evaluate the actions shall be the basis for the development of a continuous articulation with the other sectors, with have actions directly linked to food and nutrition. Professionals shall be trained also to perform due technical cooperation when demanded by other governmental

spheres, aiming at standardizing concepts and procedures.

Results

In 1999, during the implementation of PNAN guidelines, more than R$130 million were invested. For this year, there is a forecast of more than R$176 million to be invested. The measures adopted in 1999 allowed to reach relevant results, such as:

- qualification of more than 86% of Brazilian municipalities □ 4.722 □ to receive a financial incentive to fight nutritional deficiencies, concerning to the variable part of the Basic Care Minimum Level (PAB);
- regular service to more than 563 thousand children, between 6 and 23 months of age, in nutritional risk □ i.e., 92% of the estimated total, receiving nutritional complements of high caloric and proteic value;
- regular service to 281 thousand children of other ages, pregnant women and poor elders, providing nutritional complementation and carrying out other appropriate nutritional actions;
- distribution of four million mega doses of vitamin A for children between six and 59 months of age in endemic areas, such as the Northeast Region and the Vale do Jequitinhonha region;
- distribution of 673 thousand bottles of ferrous sulfate, by the community health agents in 512 municipalities of the Northeast Region;
- implementation of 15 nutritional studies and researches for the national mapping of nutritional deficiencies and the development of the Brazilian table of food composition;
- elaboration of nutritional guides according to regional diversity; production and distribution of information material on appropriate nutrition and healthy weight, directed at the population in general and at the education of basic school teachers;
- organization of database on food and nutrition, available for consultation through the Health Phone, for which 80 attendants were trained to provide information;
- establishment of agreements with the states aiming at strengthening food and nutritional coordinations; and
- iron enrichment of corn and wheat flours, according to the Social Commitment for Iron deficiency anemia reduction in Brazil, signed with the food industry.

* Technical Scientific Text by the Ministry of Health.

Avenida Dr. Arnaldo, 715
01246-904 São Paulo SP Brazil
Phone/Fax: +55 11 3068-0539

e-Mail
revsp@org.usp.br

Annex II: Interview Guide

Semi-Structured Interview Guide

Processes for the Formulation of a National Policy on Food and Nutrition

Formulation Stage

1. In your opinion, when did the Food and Nutrition issue enter the Brazilian public agenda? Why?
2. In your opinion, what were the factors (political, economical, and social) that influenced PNAN's approval in 1999?
3. Which were the players that, somehow, contributed to the formulation of the National Policy on Food and Nutrition (public managers of governmental institutions, councils of rights, NGOs, universities, etc.)?
4. Did other sectors, besides the Health Sector, took part in the discussions concerning the Policy formulation?
5. Were National Policy on Food and Nutrition guidelines discussed and negotiated? How?
6. Which were the relevant concerns in the National Policy on Food and Nutrition formulation stage?
7. Previous to the National Policy on Food and Nutrition, were there programs, projects or actions, aiming at CNCD prevention and control, implemented/executed in the federal level? Which were they?
8. Did these programs show any result? Why were they changed? Who decided to make the changes?
9. What was the priority level given to the chronic noncommunicable diseases prevention and control associated to Food and Nutrition? Why was that level given?
10. Which were the priority questions and strategic options identified in the proposal for CNCD prevention and control in the National Policy on Food and Nutrition?
11. Which were the main obstacles or challenges to the process of building a proposal for the prevention and control of Food and Nutrition related chronic noncommunicable diseases?
12. Was any demand or sector left unattended by the proposal? Why?
13. In your opinion, what was the greatest merit of the CNCD control and prevention proposal in the National Policy on Food and Nutrition?
14. In your opinion, what is the greatest gap of the CNCD control and prevention proposal in the National Policy on Food and Nutrition?

Annex III: Free and Informed Consent Form

Dear Sir/Madame,

We hereby request your consent for our participation in the research done by the Ministry of Health, Health Surveillance Secretariat (SVS), under the title **"Mapping of surveillance, prevention and control initiatives for chronic noncommunicable diseases in Brazil, 1999-2005: subsidies to formulate a national policy on integrated surveillance**", coordinated by the Health Surveillance Secretariat, National Coordination of Noncommunicable Diseases and Illnesses, Ministry of Health, under the advisory of Professor Doctor Denise Bomtempo Birche de Carvalho, from the University of Brasília.

This research has the following objectives: i) to map governmental initiatives for the prevention and control of chronic noncommunicable diseases (CNCDs) in the Brazilian federal level, in five main axis of the public health area. These axis are: the national policy on food and nutrition; the national policy for smoking prevention and control; the diabetes/hypertension watch; the promotion of physical activities and, surveillance; and, ii) to analyse the initiatives formulation process in the public actions area with a view to protect and promote health. The dada analysis will be done by means of the restoration of political fundamentals and criteria present in the decision taking process for the initiatives formulation regarding chronic noncommunicable diseases prevention and control.

All persons that took part in this study were identified by a wide research regarding chronic diseases prevention, control and surveillance as being key informants due to their active participation, knowledge and experience. Due to that, their contribution to restore the public policies formulation process in the chronic diseases area in Brazil is really important for this study.

If you agree to cooperate in the research, we will request you to dedicate some time for an interview, aiming at knowing your perspective as an actor involved in the formulation and approval process of the policy in what regards one of the five axis of the research.

The interview will take 90 minutes and will take place in a suitable place and time that provides privacy to protect your anonymity. Due to the characteristics of the study, it may be necessary to have more than one meeting so that the objective of the research be met. The interviews will be done by two qualified researchers: one will make the interview and the other will take notes. The interviews will be recorded with a cassette recorder, for which we will request your previous consent. This is the best method to allow us to retrieve your contribution. However, if you consider that some part of your contribution was not recorded in the tape, you may inform the interviewers. Afterwards the interviews will be transcribed by qualified personnel.

The information you give, as well as your personal data, will be kept confidential. Once the interviews are transcribed, the tape recorded will be erased and the transcriptions will not identify your name or the institution you represent. Only a code will be kept in a safe place, to which only the personnel in charge of the research will have access.

The results of the research may be divulged or published in reports or scientific documents of national or international scope. No name will be used to divulge the research results.

The participation in this study will not have any cost for you. Besides that, no potential risks or benefits were identified as a consequence of your participation in the study. However, your participation is of great value for the development of the public health in the country.

Your participation is voluntary, and you have the right of not participating or abandoning the project any time you want. The denial in participating in the study would not cause you any penalty, nor would interfere in your relationship with the interviewers or with the participant institutions. You will have access to the final results of the research.

If you need more information on the study, please, call us at the telephone numbers below.

Dra. Deborah Carvalho Malta
General Coordination of Noncommunicable Diseases and Illnesses
Department for the Analysis of the Health Situation
Health Surveillance Secretariat
Ministry of Health
Telephone: (61) 315-3784
Fax: (61) 315-3498

Prof. Dr. Denise Bomtempo B. de Carvalho
Department of Social Services, UnB, IH
Telephone: (61) 3307 18 18 or 3307-2290 ext. 217
birche@terra.com.br

I, _____, have read and understood the explanations given in the previous letter on the research performed by the Ministry of Health, Health Surveillance Secretariat (SVS), called **"Mapping of surveillance, prevention and control initiatives for chronic noncommunicable diseases in Brazil, 1999-2005: subsidies to formulate a national policy on integrated surveillance**", coordinated by the Health Surveillance Secretariat, National Coordination of Noncommunicable Diseases and Illnesses, Ministry of Health, under the advisory of Professor Doctor Denise Bomtempo Birche de Carvalho, from the University of Brasília.

I understand I will participate of a 90 minute long interview, which will be recorded and transcribed. Besides that, if I wish, I may get in advance a copy of the topics that will be

discussed in the interview. I also understand that the information I provide will be kept confidential and that the analysis will be divulged or published in national and international scope.

I am informed that there are no known risks for my participation in this study and that I will have no financial cost. Besides, I may decide not to participate of the research or even abandon it any time I want.

I read and understood the information letter and this Consent Term. I know that I can contact the coordinators of the study on the telephones informed in case I need to obtain more information on the development of the research.

YES, I agree to participate in this study as a key informant.

_____	_____	_____
Informant Name	*Identity no.*	*Signature*
_____	_____	_____
Name of the Witness	*Identity no.*	*Signature*
_____	_____	_____
Name of the Coordinator	*Identity No.*	*Signature*

Prof. Dr. Denise Bomtempo B. de Carvalho
University of Brasilia
Institute of Human Sciences
Post Graduation Program on Social Policy
Tel. (61) 3307 18 18 - 3307-2290 ext: 217
birche@terra.com.br