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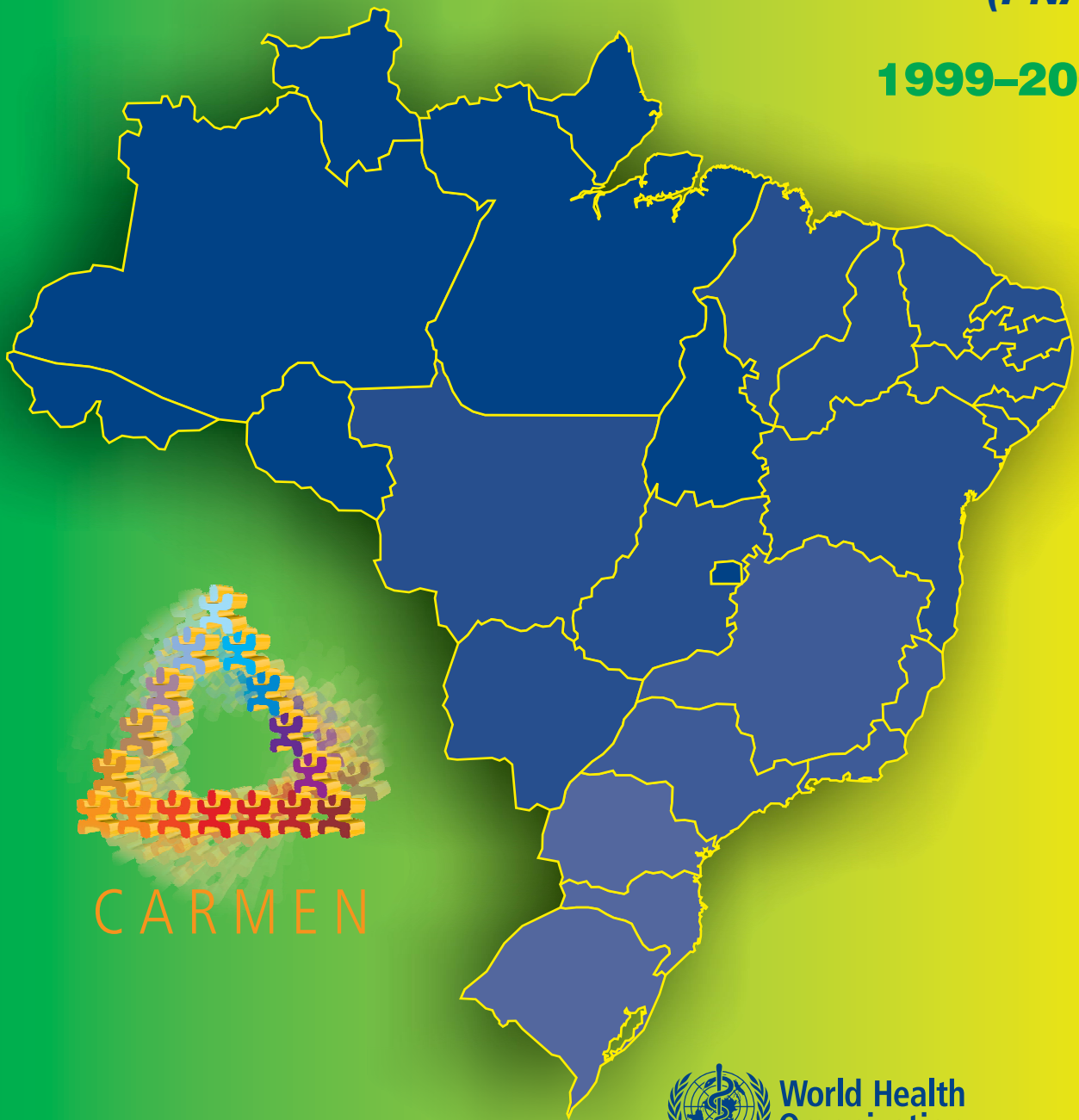
Observatory on Chronic Noncommunicable Disease

The Case of Brazil

National Food and Nutrition Policy (PNAN)

1999–2005



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World Health Organization

WHO Collaborating Centre on Chronic Noncommunicable Disease Policy

Saúde
Ministério da Saúde
Ministry of Health
Health Surveillance Secretariat
Health Condition Analysis Department
General Coordination of Noncommunicable Diseases and Health Conditions

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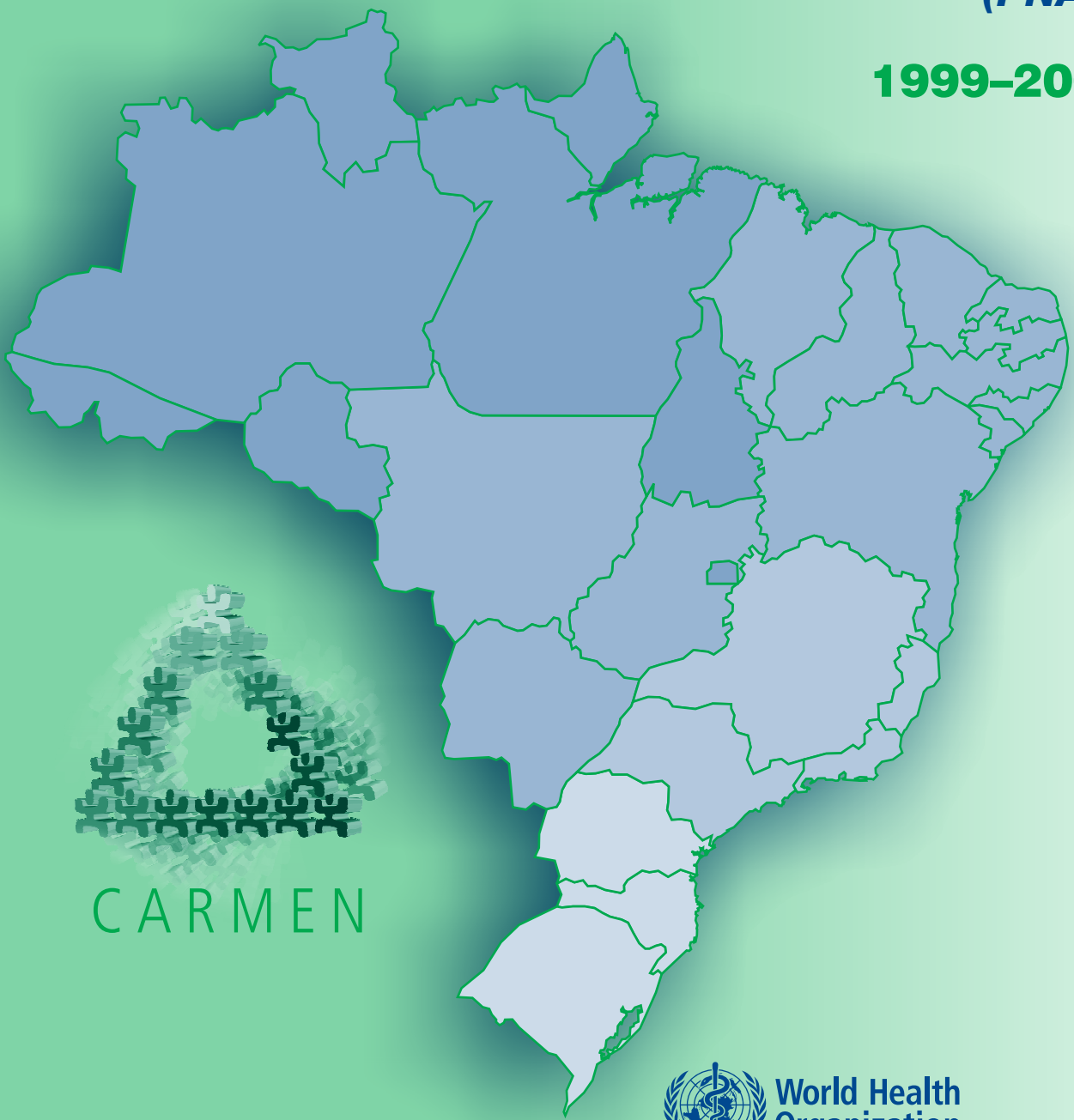

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World Health Organization
WHO Collaborating Centre on Chronic Noncommunicable Disease Policy

Brasilia, June 2006

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ABBREVIATIONS

ABIN	Brazilian Association of the Nutrition Industry
ASBRAN	Brazilian Nutrition Association
ABSAN	Brazilian Association for Food and Nutritional Safety
ABRANDH	Brazilian Association on Food and Nutrition and Human Rights
ANS	Supplementary Health Agency
ANVISA	Brazilian Health Surveillance Agency
ATAN	Food and Nutrition Technical Sector
BEMFAM	Family Well-being in Brazil
CFN	Federal Nutrition Council
CGDANT	General Coordination of Noncommunicable Diseases and Health Conditions
CGPAN	General Food and Nutrition Policy Coordinator
CGPNPS	Management Committee for the National Health Promotion Policy
CIAN	Intersectoral Commission on Diet and Nutrition
CNA	National Diet Commission
CNAE	National School Meals Commission
CNAS	National Council for Social Service
CNRH	National Human Resources Centre
CNS	National Health Council
CNSAN	National Conference on Food and Nutrition Security
COBAL	Brazilian Diet Corporation
CONAB	National Supplies Company
CONASEMS	National Council of Municipal Health Secretariats
CONASS	National Council of Health Secretariats
CONEP	National Commission for Research Ethics
CONSEA	National Council on Food security
CSA	Food Security Council
CSUs	Urban Social Centres
DANTs	Noncommunicable Diseases (NCDs)
(NICD) DCNT	Chronic Noncommunicable Diseases and Health Conditions (CNCD)
DCV	Cardiovascular Diseases (CVD)
DHAA	Human Right to Adequate Food
DHS	Demographics and Health Research
EMBRAPA	Brazilian Agricultural and Livestock Research Company
ENDEF	National Family Expenditures Study
ENSP	National School of Public Health
FAO	United Nations Food and Agriculture Organization
FAE	Student Welfare Foundation
FBSAN	Brazilian Forum on Food and Nutritional Safety
FIBGE	Brazilian Institute of Geography and Statistics Foundation
FIOCRUZ	Oswaldo Cruz Foundation
FSESP	National Foundation of Public Health Services
FUNASA	National Health Foundation
IBASE	Brazilian Institute of Social and Economic Analysis
IBGE	Brazilian Geography and Research Institute
ICCN	Incentive for the Fight Against Nutritional Deficiencies
IDEC	Brazilian Consumer Protection Institute
IHAC	Baby Friendly Hospital Initiative
IMIP	Pernambuco Mother/Child Institute

INAE	National Institute for Student Assistance
INAN	National Food and Nutrition Institute
INCA	National Cancer Institute
INESP	Higher Education and Research Institute
INCQS	National Institute for Quality Control in Health Care
IPEA	Institute of Economic and Applied Research
IPLAN	Government Planning and Management Institute
LACENS	Central Public Health Laboratories
LOS	Organic Health Law
MDA	Ministry of Agrarian Development
MCT	Ministry of Science and Technology
MDS	Ministry of Social Development and Hunger Eradication
MAPA	Ministry of Agriculture, Livestock and Supply
MP	Public Ministry
OAB	Order of Brazilian Lawyers
OMS	World Health Organization (WHO)
OPAS	Pan American Health Organization (PAHO)
OPDCNT	Chronic Noncommunicable Diseases Surveillance, Prevention and Control Policy Observatory
PAB	Primary Care Floor
PACS	Community Health Agents Program
PAE	Economic Action Plan
PAN	Nutritional Support Program
PASEP	Civil Servant Patrimony Structuring Program
PAS	Safe Foods Program
PASS	Social Action and Sanitation Program
PAT	Worker's Food Program
PBA	Food Allowance Program
PBEM	Program for the Well-being of Minors
PCA	Supplementary Food Program
PCFM	Plan for the Fight Against Hunger and Misery and in Support of Life
PCF	Plan for the Fight Against Hunger and Misery and in Support of Life
PCS	Community Solidarity Program
PED	Strategic Development Plan
PGRM	Minimum Income Assurance Program
PIASS	Program for Decentralization of Health and Sanitation Services
PIE	Employment Mediation Program
PIS	Social Integration Plan
PLANFOR	National Program for Vocational Education
PNAA	National Program for Access to Food
PNAE	National School Meals Program
PNAN	National Food and Nutrition Policy
PNCC	National Program for Building the Capacities of Cities
PNAD	National Household Survey
PNDS	National Demographic and Health Survey
PNBEM	National Policy for Child Welfare
PND	National Development Plan
PNI	National Immunization Program
PNIAM	National Program to Promote Breastfeeding
PNLCC	National Milk for Needy Children Program
PNM	National Child Program

PNS	Nutrition in Health Program
PNSA	National Council on Food Security
PNSN	National Health and Nutrition Program
PPA	Multi-year Plan
PRODEA	Emergency Diet Distribution Program
PRODECOR	National Rural Community Development Program
PROGER	Program for Creation of Employment and Income
PRONAF	National Program to Strengthen Family Agriculture
PRONAN	National Food and Nutrition Program
PSA	Food Security Policy
PSA	Supplementary Food Program
PSMI	Mother-Infant Health Program
SAN	Food and Nutrition Security
SAS	Health Assistance Secretariat
SALTE	Health, Food, Transportation and Energy
SAPS	Social Welfare Food Service
SBSA	Brazilian Soil for Food Security
SEAC	Community Activity Secretariat
SINE	National Employment System
SISVAN	Food and Nutrition Surveillance System
SNME	National School Lunches Service
SNVS	National Health Surveillance System (SNVS)
SPS	Health Policies Secretariat
SUS	Unified Health System
SGEP	Strategic and Participatory Management Secretariat
SGTES	Labour Management and Health Education Secretariat
SCTIE	Science, Technology and Strategic Supplies Secretariat
SVS	Health Surveillance Secretariat
TCLE	Free and Informed Consent Form
UFBA	Bahia Federal University
UFPE	Pernambuco Federal University
UNICEF	United Nations Children's Fund
USP	São Paulo University
VISAS	State Centres for Health Monitoring – Federal District and Municipalities

ZERO HUNGER PROGRAM

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Introduction

This research focuses on two fundamental but complementary aspects:

1) Mapping government initiatives to prevent and control Chronic Noncommunicable Diseases (CNCD) in Brazil, examining five basic components of the field of public health: the National Food and Nutrition Policy (PNAN), the National Tobacco Control Policy, Diabetes and Hypertension Watch, Physical Activity, and Surveillance.

2) Analysing the process of formulating these initiatives to protect and promote health. This analysis will be based on the reconstitution of policy fundamentals and criteria within the decision-making process for formulating CNCD prevention and control initiatives.

Analysing CNCD in the broad sense and considering the debate taking place in the area of public health (LESSA, 1998, 2004), since the 1960s, we have been seeing changes in morbidity and mortality patterns occurring within the population. This phenomenon is characterized, among other indicators, by a visible decrease in the number of deaths from infectious diseases and gradual increase in deaths from noncommunicable diseases.

This process, known as epidemiological transition, represents the reflection in the field of public health of a series of more general changes that have taken place in the dynamics of community life, such as demographic, economic and social changes and an increase in exposure to unhealthy behaviours such as smoking, sedentarism, and improper eating habits.

According to Ministry of Health data (2004), in Brazil, Chronic Noncommunicable Diseases (CNCD) were responsible for a great deal of the deaths and hospital care expenses within the Unified Health System (SUS), accounting for roughly 69% of health care expenses in 2002. Since the 1960s, cardiovascular diseases (CVD) have been the leading cause of death in Brazil and, at the present time, are the primary cause of death in about two thirds of deaths from known causes (BRAZIL, MINISTRY OF HEALTH, 2004).

In 2003, these diseases caused 274,068 deaths, 31.5% of deaths from known causes (Table 1), in the following proportions (Table 2): cerebrovascular diseases (32.5%), ischemic diseases (30.4%), hypertensive diseases (10.2%), and cardiac insufficiency (9.9%).

Table 1: ***Deaths by Group of Causes, Brazil, 2003***

Causes of Death	No. of Deaths	%
1 Cardiovascular Diseases	274,068	31.5%
2 Neoplasies (tumours)	134,691	15.5%
4 External Causes	126,657	14.6%
5 Respiratory Diseases	97,656	11.2%
6 Endocrine, Nutr. and Met. Diseases	51,190	5.9%
7 Digest System Diseases	46,894	5.4%
8 Infectious and Parasitic Diseases	46,533	5.4%
9 Perinatal Diseases	32,040	3.7%
10 Other	59,177	6.8%
Total Deaths from Known Causes	**868,906**	**86.69%**
3 Unknown Causes	133,434	13.31%
Total Deaths	**1,002,340**	**100.00%**

Source: *SIM/MS* **Prepared by:** *CGDANT/DASIS/SVS/MS*

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

	North	Northeast	Southeast	South	C-West	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	32.5%
Ischemic Heart Diseases	2,411	14,705	45,156	16,293	4,629	83,194	30.4%
Acute Myocardial Infarction	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 Cardiac 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%
Cardiomyopathies	343	2,206	7,554	1,517	1,326	12,946	4.7%
Arterial Diseases (Includes Aneurysms)	191	1,286	6,148	1,848	687	10,160	3.7%
Cardiopulmonary and Pulmon. Vascular Diseases	199	719	3,521	1,020	296	5,755	2.1%
Arrhythmia	146	617	2,772	889	350	4,774	1.7%

Source: *SIM/MS* **Prepared by:** *CGDANT/DASIS/SVS/MS*

Table 3: ***Number and Increase (%) among the Elderly and the Total Population of Brazil from 1991 to 2000, by Age Group***

	Year		Increase	
Age Group	**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* **Prepared by:** *CGDANT/DASIS/SVS/MS*

In recent decades, CNCD prevention has become a concern to public authorities and various international organizations due to Brazil's demographic transition and the increase in the population of older people (Table 3) and the high incidence of such diseases within this segment of the population.

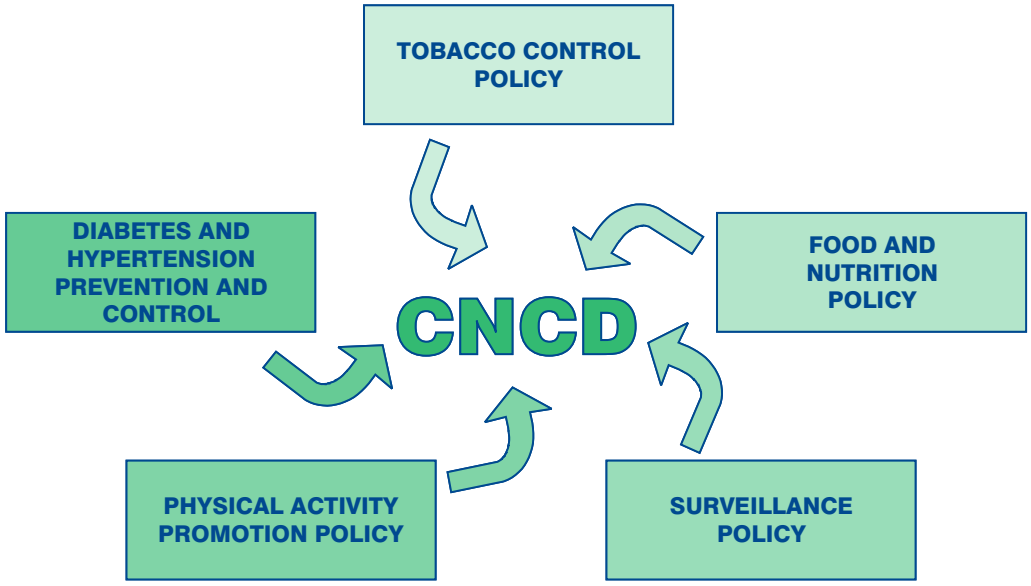
NICD prevention and management strategies and activities have been developing in Brazil for over almost a century (BRAZIL, MINISTRY OF HEALTH, 2002). However, such activities are institutionally fragmented, since they are organized and conducted by a number of different ministries, with no apparent coordination among them, which may lead to overlapping of efforts and reduced efficiency and effectiveness.

Thus, faced with the recognized complexity inherent in CNCD and the resulting impact on the Brazilian Health System of a possible epidemic of these diseases, including the impact on the funding of health service activities, the need to conduct a thoughtful and comprehensive public debate on the formulation of a National Policy on the Prevention and Control of Chronic Noncommunicable Diseases becomes obvious.

As a result of these concerns, this project was conceived as the result of a broad participatory process involving the Ministry of Health, the CNCD Surveillance, Prevention and Control Policy Observatory (OPDCNT), the Pan American Health Organization (PAHO), the Canadian Health Agency and Collaborating Centres in Brazilian universities.

The main objective of the proposal is to organize and analyse procedures for formulating government public policies on CNCD prevention and control at the federal level in five fundamental aspects of public health: 1) Food and Nutrition Policy; 2) Tobacco Control Policy; 3) Diabetes and Hypertension Prevention and Control; 4) Physical Activity Promotion Policy; 5) Surveillance Policy, as shown in the following diagram:

Brazilian Case Study: 5 Aspects of Analysis



This analysis included the decision-making process for formulating these initiatives within the various sectors of the Ministry of Health. This is because while all governmental programs have a technical performance content, with activities proposed according to rational criteria, all of them also have a political content. Government activities and/or programs are carried out within a highly political environment.

Government intervention in social reality is complex. The formulation of government policies and/or programs depends on interaction among political groups within the Nation and their interaction with organized society. Therefore the political weight of government action must be taken into account when analysing programs, above all when the objective is to analyse the process of formulating public government policies.

The Policy Observatory was implemented with the aim of contributing to the technical capacity to analyse and assess CNCD prevention policies in Latin America and the Caribbean. It was responsible for the classification and analysis, with methodological accuracy, of information regarding policies related to the prevention of chronic noncommunicable diseases. "This Observatory will have the capacity to assess changes in interventions in the region and will be responsible for distributing the results of its analysis as well as other results considered relevant" (PAHO, 2003).

Within this context, WHO, in partnership with the Collaboration Centre in Canada for the development of chronic noncommunicable disease 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 initially involved the process of analysing public health policies on CNCD. The present research is part of this proposal.

The research attempted to respond to the following investigation issues:

- How can government initiatives for CNCD control and prevention be included within a future more global strategy to deal with this problem?
- How can these initiatives provide input for the formulation of an integrated public policy for CNCD prevention and control in Brazil?

Objectives of the Brazilian Case Study

- To outline the initiatives for chronic noncommunicable diseases prevention in Brazil with respect to food and nutriton policy, tobacco control policy, diabetes and hypertension prevention and control, physical activity promotion policy and surveillance policy;
- To analyse the process of formulating these public action initiatives with a view to protecting and promoting health;
- To analyse how such initiatives may be included within a future more global strategy to deal with this problem and to formulate an integrated policy for CNCD prevention and control in Brazil;
- To identify features that facilitate or hamper the formulation and approval of policies in this area;
- To support the formulation of an integrated policy for CNCD prevention and control in Brazil;
- To analyse Brazilian results compared with CNCD prevention and control policy formulation procedures in Costa Rica and Canada.

3 Theoretical and Methodological Approach

In order to better identify research tools, it is necessary to understand the meaning of a given public policy analysis. There is little consensus on this and the analyst is therefore obliged to declare, from the beginning, what his/her preferences and choices are (Draibe, 2001).

By public policy analysis, we mean the assessment of the institutional engineering and other features making up the programs. Any public policy may be formulated and implemented in several ways. The choice of a given formulation and implementation – from the point of view of the forms of funding, the modalities of providing the services, relationship between public and private sectors, etc. - instead of another is the subject of the analysis, during which we intend to reconstitute the different characteristics so as to be able to understand them as a coherent and comprehensible unit.

However, although the analysis of a given public policy may attribute some of the probable results to a given institutional design, only assessment of this policy may assign a causal relationship between a given modality of public activity and success or failure in the attainment of its objectives, or between this activity and a given result or impact on the social situation before it occurs.

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

> *"Policies and programs are living things. They are born, grow, change and develop. Eventually, they stagnate, and sometimes die. They go through a lifecycle, a process of development or maturation and, sometimes, aging or weakening (...) But policies and programs are made of flesh and bones, or better, of body and soul. They are determined and prepared by people, and are directed at people or their habitat. They are managed and implemented by people and, when this occurs, they are also assessed by people – the people and groups of people who give life to these policies act in accordance with 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, and conflicts that arise and are resolved through time."*

The political contents of policies constitute what could be called a *political economy of public policies* (DRAIBE, 2001), since they refer to the direction and logic of program dynamics, driven by concerns, conflicts and possible negotiations. This is when policies are formed and formulated, when the initial decisions are made and strategies defined.

Although such processes are interdependent, a more detailed conception of the stages of a policy distinguishes at least two specific moments before

implementation. The formation phase implies the drafting of an agenda, the definition of concerns and the identification of alternatives. The formulation phase is when the various proposals are transformed into the policy itself, by setting goals and objectives, defining resources and announcing policy development strategies.

In as much as various authors have dealt with the assessment and analysis of public policies, the analysis method used in this Project distinguishes two important stages in the lifecycle of government programs: the predecision phase, involving the processes of formulating the public agenda and comparing alternatives, and the decision phase, where decisions are authorized by the government agents concerned with formulating the programs.

The predecision and decision processes for 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, the demands onto the social agenda and, subsequently, the public agenda); the production and comparison of alternatives by different groups of stakeholders; the processes of selection and appropriation by agents, in accordance with the organization's legacy or its traditions and cultures. The second phase refers to the formulation, involving mainly the decisions made regarding characteristics such as the timing of activities, the strategic stakeholders to be mobilized in support of policy development , the goals to be attained, the scope of the activities, and the resources available, which will result in laws, decrees, interim measures, regulations, etc.

The concept of a program cycle made up of phases or stages was adopted for methodological systematization purposes, since, although certain cycles have their own inherent characteristics, it is difficult to completely separate them, because the stakeholders involved are dynamic and creative.

The description of the methodology used is essential for understanding the steps that must be taken to develop a case study: analysis of the constitution of the public agenda, identification of the comparison of proposals, definition of CNCD prevention and control policies or strategies within the five aspects described, explaining their design, scope and objectives.

The reconstruction of the processes of forming and formulating the initiatives to be analysed takes into consideration the existence of a series of decisions made by various stakeholders, who influence and orient the configuration of the activities as proposed.

According to Castro (2000, p. 2):

> *"It is accepted that, during this process, various stakeholders are present. They plan and act on the basis of different perspectives according to their understanding and interpretation of reality and in accordance with their needs, requirements and aims and the different capacities for action they have, given the power resources they control. In the articulation processes, these stakeholders clash and reach (or fail to reach), by mutual agreement, decisions on political interactivities, decision-making arenas, with respect to maintaining and/or increasing their respective areas of control of power resources available to the State. In each of these decision-making areas, decision centres are defined for the policies being formulated and implemented."*

We will use the conceptual model by John W. Kingdon (1995) to analyse the process of formulating public policies, which is the subject of our research.

Kingdon focuses on understanding the main predecisional processes leading to the implementation of a social policy: the establishment of an agenda and specification of alternatives. A government agenda consists of a list of items to which government authorities are paying any attention at a given moment. Alternatives specification is the process by which some options are actually selected from a set of feasible alternatives.

Government Agenda

In this design process, three inter-related stages were defined: problems, policies and politics. Social stakeholders recognize problems, make proposals to reformulate public policies and engage in political activities, such as electoral campaigns or political action by pressure groups (advocacy). Each participant – the President, members of the National Congress, public servants, lobbyists, journalists, university professors, etc. – may, in principle, be involved in any of these three processes (recognition of problems, development of proposals and politics).

Problems: recognizing problems is a crucial stage in defining an agenda. As an agenda is drawn up, the possibilities for a topic or proposal are visibly strengthened if they are linked to an important problem that in some way violates common values.

Politics: the second explanation for the relative position of a topic on the agenda is the political trend. Independently of the recognition of problems or the development of political proposals, political events move according to their own dynamic and their own rules. Actors notice changes in the national political environment, elections bring new administrations and new parties or ideological configurations to the National Congress and the various pressure groups impose (or fail to impose) their demands on government.

Visible Participants: In third place, the visible participants, those who are the targets of considerable pressure and public attention, including the President of the Republic, senior public servants, members of the National Congress, the media, and stakeholders involved in the electoral process, such as political parties and political campaign directors, also influence the formulation of an agenda.

Specifying Alternatives

The alternatives are created and defined within the flow of policies, with the participation of relatively unknown stakeholders.

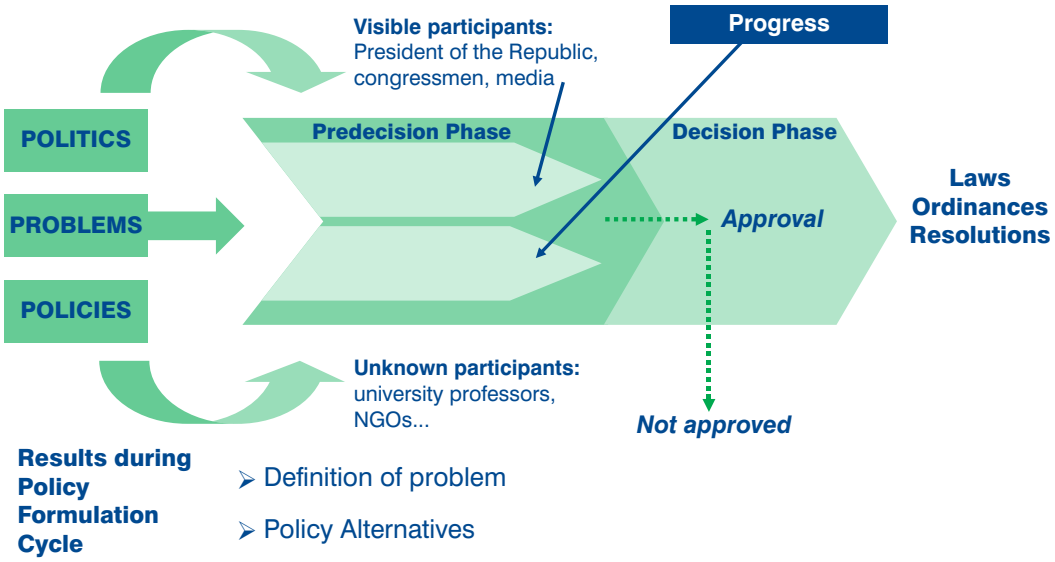
Policies: the forming of policy alternatives is understood as a selection process. It is a "wave" of policies. Many ideas appear, clash, lead to new ideas, and new combinations and recombinations are proposed. Where and how policies originate may seem obscure, and difficult to understand and organize.

Unknown participants: alternatives and solutions are produced within communities of experts. These groups are comprised of university professors, non-governmental organizations (NGOs), courts and analysts. Their work is expressed in planning and

assessment or in proposed negotiations with members of the National Congress. The proposals are discussed in draft legislation, public hearings at the National Congress, the publication of articles, etc.

Kingdon's (1995) proposed analysis guide may be diagrammed as follows:

Framework to Analyse the 5 Aspects of Mapping



Source: *(Kingdon 1995, based on diagram by M. Barzelay and Cortazar, J. C. 2003, adapted from Carvalho, October 2004)*

According to Kingdon (1995), each of the three trends – politics, problems and policies – and each type of participants has its specific dynamics and may act as a stimulus or restraint with respect to a given problem/alternative being placed on the agenda. When all three flows come together, forming what the author calls "interlock", the possibility that the problems and alternatives will be included in the decision phase (decision agenda) increases significantly.

When decisions are made, the public participants – president, ministers, senior officials and congressmen - play a central role, although unknown participants also participate. At this stage, official decisions are made by means of formal mechanisms (laws, decrees, interim measures, and resolutions), authority is granted, obligations and rights are established, and resources are granted using public authority.

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

- How and when was the CNCD issue placed on the agenda of the Brazilian government?
- What were the alternative solutions proposed by the various government stakeholders for CNCD prevention and control problem?
- What policy, program and action options were selected to deal with the problem?
- Why were certain alternative solutions favoured in policies, programs and/or action?

4 Methodological Procedures

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

The method used was the comparative case study among empirical analysis units selected by members of the Policy Observatory. These units are: a) food and nutrition policy; b) tobacco control policy; c) diabetes and hypertension prevention and control; d) physical activity promotion policy; e) surveillance policy. This report presents the results for a single case (National Food and Nutrition Policy) since the other components of the research design will be carried out later in accordance with the schedule of the Policy Observatory, Brazilian case study.

These units were chosen for analysis because of the great contribution they may make to the prevention of chronic noncommunicable diseases (BRAZIL, MINISTRY OF HEALTH, 2002) within the Brazilian context.

For Yin (2005), "in general, case studies are more important when answers are sought to 'when' and 'why' questions in situations where the researcher has little control over events and when the focus is placed on contemporary events within the context of real life", especially when the "limits between event and context are not clearly defined".

Analysis Unit: National Food and Nutrition Policy

Since the method defined was the case study, the establishment of the analysis unit corresponds to the definition of the "case" to be studied (YIN, 1984; apud ALVES-MAZZOTTI and GEWANDSJNAJDER, 1998).

Different aspects were considered in choosing the National Food and Nutrition Policy (PNAN) as a comparative study analysis unit: i) it is a multisectoral Federal Government guideline, under the joint responsibility of the Ministry of Health, the Ministry of Planning, Budget and Management, the Ministry of Social Development and Hunger Eradication, and the Ministry of Education, among others; ii) PNAN is consistent with national objectives regarding CNCD; iii) it is a sectoral policy and national in scope; iv) it involves one of the main factors for protection against CNCD, the promotion of healthy nutrition; and v) PNAN has a component that intersects with other governmental public policies, which gives it potential for universality.

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

PNAN formulation was coordinated by the then Health Policies Secretariat, with the participation of various government sectors, segments of society and experts on the issue. It was subject to appraisal by the Tripartite Inter-Management Commission and the National Health Council.

PNAN, like other government initiatives, belongs to the "set of government policies for the implementation of the universal human right to adequate food and nutrition" (BRAZIL, MINISTRY OF HEALTH, 2003, p. 17).

To attain these goals, the following were defined as PNAN political-institutional guidelines (BRAZIL, MINISTRY OF HEALTH, 2003, p. 19):

- Encouraging intersectoral activities to promote universal access to food;
- Guaranteeing food safety and quality and services within this context;
- Monitoring the food and nutrition situation in Brazil;
- Promoting healthy eating habits and lifestyle;
- Preventing and controlling nutritional disorders and diseases associated with eating and nutrition;
- Promoting the development of lines of investigation; and
- Developing and training human resources.

The investigation questions that guided the analysis of the processes for formulating PNAN were the following:

- What social, institutional and political contexts make the process of formulating PNAN viable?
- How, within the scope of PNAN, was the prevention of CNCD included in the public agenda?
- What collective health problems motivated this initiative?
- What are the alternative solutions proposed by the various government and non-government stakeholders dealing with this problem?

Data Collection

To answer these basic questions and attain the research objectives, both secondary and primary data sources were used.

Secondary Data

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

- Laws that created and controlled the activities and programs being analysed;
- Presidential decrees, legal directives, plans, bulletins, reports issued by the relevant government agencies;
- Publications of international organizations;
- Articles in national newspapers;
- Speeches, reports, opinions;
- Records of inter-ministerial and intra-ministerial meetings and workgroups;
- Reports on organized events; and
- Others.

Primary Data

Sixteen semi-structured interviews were conducted with key stakeholders, following an interview guide (Appendix 2), and using the following selection criteria:

- Participants suggested by the Policy Observatory on chronic noncommunicable diseases;
- Public administrators who participated in the process of formulating PNAN in several public policy sectors;
- Experts in basic health epidemiological evidence related to food and nutrition; and
- Experts in food and nutrition with proven experience in formulating food and nutrition programs and activities.

Key players named by the Policy Observatory on chronic noncommunicable diseases in Brazil, who did or do take part in the following governmental institutions: General Food and Nutrition Policy Coordinator (CGPAN/MS); General Coordination of Noncommunicable Diseases and Health Conditions (CGDANT/MS); Applied Economic Research Institute (IPEA/MP); Oswaldo Cruz Foundation (FIOCRUZ/MS); Ministry of Science and Technology (MCT); 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 associated with the non-governmental organization, the Brazilian Association on Food and Nutrition and Human Rights (ABRANDH) were also interviewed.

The interviews with government and non-government stakeholders involved in the public agenda formation and action/program formulation stages made it possible to reconstitute the process and the action of stakeholders, as well as their motivations and concerns in the area of food and nutrition in Brazil.

Interviews were conducted by a team of four research assistants associated with this group and the principal researcher. The researchers were trained in ethical, theoretical and methodological aspects of data collection procedures in qualitative research, mainly with respect to the relationship between the researcher and the interviewee, the

reciprocal relationship and moments of understanding and explanation regarding the issues being interpreted on the part of both the interviewee and the researcher.

In order to comply with the resolution of the National Commission for Research Ethics (CONEP) of the National Health Council, the process was duly forwarded by the Health Surveillance Secretariat of the Ministry of Health to the regulatory authorities. Each key informant invited to participate in the research was requested to sign the "Free and Informed Consent Form" (TCLE), as recommended by CONEP/MS standards (Appendix 3). Also with respect to the ethical aspects of the research, we should point out that the interviewees' names are omitted in order to protect their identities as is usual in qualitative research.

Organization and Systematization of the Statements/Reports from Key Informants

The qualitative methodology sets out some key issues during the organization of the study subject and the theoretical and methodological interventions selected, such as, through open interviews, a complete discourse corpus from various social stakeholders involved in the phenomenon of CNCD prevention, how can these basic questions about the research subject be answered? How are we to interpret the significance of the subjects' experiences and practices with open interviews? How can the subjects' inherent subjectivity be considered scientific knowledge?

To understand the complexity of the process of formulating CNCD prevention policies, programs and projects, all recorded interviews had to be transcribed, maintaining the unity of narration and preserving the context within which the speech occurred. These features hold a specific meaning for both interviewee and interviewer.

The interpretation of qualitative data collected in semi-structured interviews was developed in phases, using the "content analysis" method developed by Bardin (1979). This comprises a series of communication analysis techniques aimed at understanding the contents provided by interviewees between the lines, stated or unstated reactions, revealed or concealed meanings, using qualitative material. Beginning with the research objectives and selection of the thematic content analysis technique (search for most recurrent themes and meanings in the words of the interviewees), the following primary data analysis procedures were performed:

1. Complete transcription of recorded interviews, aiming at doing a preliminary analysis of the content;

2. Constitution of a corpus and preservation of the discursive structure: aimed at protecting the context and unity of the interviews. This phase consists in grouping interviews, aiming at structuring narratives according to the objectives and qualitative components of the research and the dimensions of the interview guide. In this phase, the analysis categories were compared, each one corresponding to a question in the interview guide (Appendix 2). This is the information organization phase (MINAYO, 1996), attempting to respond to certain validity standards, such as: a) completeness (whether the corpus represents all aspects of the interview guide); b) representativity

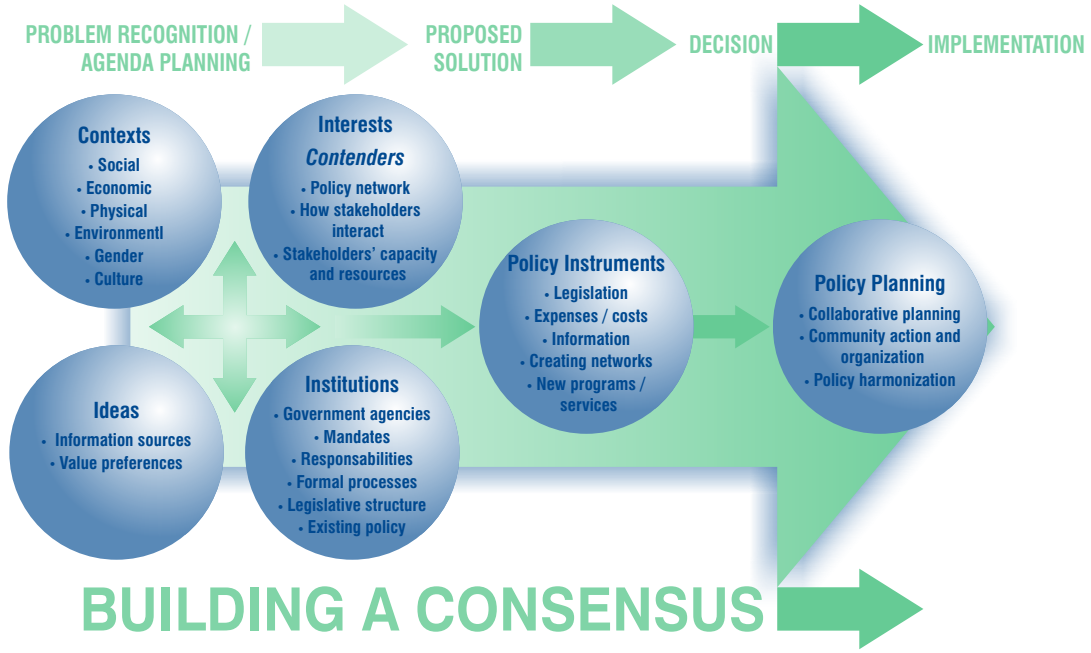
(whether- the corpus represents the contributions of all stakeholders); and c) relevance (whether the analysed data is appropriate for the research objective); and

3. Data interpretation based on the analytical chart (framework) organized by the Policy Observatory, as will be seen in the following item.

Structure for Analysing the Development of the National Food and Nutrition Policy

Between January and November 2005, the Canadian Collaboration Centre, with contributions from Brazilian and Costa Rican teams, organized the analysis chart in order to support the analysis of the public policies selected for study at the Observatory. Five categories of interconnected factors were created: context, ideas, institutions, concerns and policy instruments (CLOTTEY, 2005), according to the following diagram:

Structure for Analysing the Political Process



Context

Context refers to the environment external to the policy formulation process within which situations, information and pressures arise. Influences may be international, national or regional in scope, with political, social or regional features, many of them beyond the control of the policy formulator. Evidence of precarious or alarming health conditions among the population or epidemics or expected pandemics have recently led to a serious rethinking of public health policy in many countries in order to deal with communicable and chronic noncommunicable diseases.

The focus must therefore be placed on PNAN formulation processes in Brazil, respecting structures and political, economic, social and cultural contexts. In the Brazilian interview guide, the key question for understanding the context is the following: "In your opinion, what national and international (economic, social and political) factors influenced the

inclusion of diet and nutrition in the public agenda and the formulation of the National Food and Nutrition Policy in 1999?"

Ideas

Ideas refer to the value preferences of government and non-government stakeholders involved in the process of formulating PNAN. The Brazilian interview guide gives priority to the following issues: In your opinion, when did the issue of food and nutrition first become incorporated into Brazil's public agenda? Who were the stakeholders who contributed in any way to the formation of the agenda and, therefore, to PNAN formulation? Among the stakeholders involved and the alternative solutions, is there any demand or sector that was not considered?

Interests

Analysis of the processes of establishing the agenda and formulating public policies that give priority to interests and conflicts is an attempt to monitor the influence of pressure groups, the interaction among the main stakeholders in the process, the ability to make a case, and the negotiation of concerns and conflicts that culminate in the choice of one alternative solution within specific economic, political, institutional and social contexts. Three questions were selected from the Brazilian interview guide in order to understand the interests and arguments of the stakeholders in the area of food and nutrition: Did any public policy sectors other than the health sector take part in the debates regarding PNAN's formulation? What are PNAN's weaknesses with respect to CNCD prevention and control? What are PNAN's merits with respect to CNCD surveillance, prevention and control?

Institutions

This is an attempt to understand the actions of government and non-government institutions with formal mandates, leadership and decision-making structures in the National Food and Nutrition Policy formulation process. In this connection, the Brazilian interview guide highlights three relevant issues: What priority was given to CNCD prevention and control guidelines associated with food and nutrition? Before PNAN was created, were there any programs, activities and services implemented with a view to preventing and controlling chronic noncommunicable diseases? What were the results of these programs and activities?

Policy Instruments and Action Plans

The focus on policy instruments and activity plans refers to all laws, regulations, new programs and services put into practice by the government for the development of a National Food and Nutrition Policy in Brazil. The basic issues that make up this aspect of the analysis are: What plans, programs and services were formulated and put into practice by the government to deal with the issue of food and nutrition during the period from 1999 to 2005? What political, economic and social factors and situations influenced the choice of instruments and action plans?

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

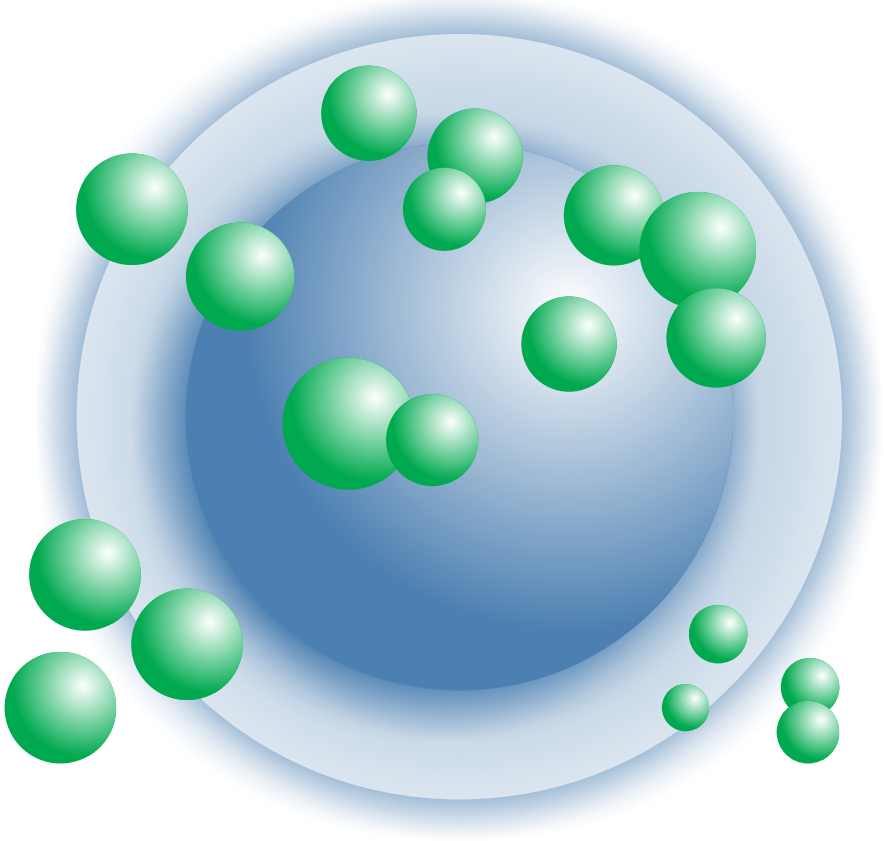
According to Merrien (2000), within the domain of the State, there are sectors and sub-sectors that cooperate in the process of organizing and implementing public policies together with civil society groups, thus forming a political network.

According to this author, the use of the network idea reveals a dialectical movement between State and civil society interested in formulating and implementing public policies within a given area of intervention. There are not two monolithic blocks, but sectors and sub-sectors within both the State block and the civil society block and, among them, there may exist more or less institutionalized networks, indicating the existence of public policy communities.

Again according to Merrien (2001, p. 65), public policy communities are made up of stakeholders with a direct or indirect interest in a subject of policy: for example, health, social welfare, education, agriculture, or food and nutrition. The members of a public policy community are not necessarily organized into networks, although such networks do exist, so it is necessary to distinguish "public policy networks", made up of members of one or more public policy communities that interact in the debate on ideas and interests regarding a subject of public policy in a given area. The policy communities demonstrate common interests with respect to certain problems and defend alternative solutions to problems in accordance with their ideas, values, institutions and strategies. They meet and establish a way to cooperate in order to better serve the interests they defend, and in the end form virtual "epistemic communities" with a specific language to interpret public policy problems, establish agendas and find alternative solutions.

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

Public Policy Community



Sources of Additional Data

Analyses and interpretations were complemented by other data sources:

- Records of seminars organized in Brasilia from October 2004 to August 2005, aimed at monitoring the political and technical discussions for the structuring of the CNCD Prevention Policies Observatory in Brazil.
- Continuity of the survey of bibliographic research in the health and social sciences, with respect to theoretical, conceptual and methodological aspects involving the study subject. The literature survey covered all phases of the research.

History of Processes for Formulating and Implementing Action to Deal with Food and Nutrition Related Problems in Brazil

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

The issue of food and nutrition in Brazil came onto the national public agenda under various different political, economic and historic situations. The first time this subject was discussed as a necessity was with the publication in 1946 of the first edition of *Geografia da Fome* [Geography of hunger] (CASTRO, 1946) by scientist, doctor, professor and politician Josué de Castro. This work was the first examination of this critical Brazilian scourge, and warned that hunger is not only a biological, but also a social issue.

According to Arruda (2005), an investigation was conducted in the 1930s into the "living conditions of the working classes", coordinated by Josué de Castro under the auspices of the Public Health Department of the State of Pernambuco.

One interviewee declared that the food and nutrition issue came onto the Brazilian public agenda between 1938 and 1940, when the minimum wage was first introduced, largely under the influence of Josué de Castro, establishing the basic budget of a family, 50% of which spent on food, which at that time was enough to buy 12 food items.

> *"I believe that this [the creation of the minimum wage] was the first point. Shortly after that, the so-called School Snack was launched in Brazil. Some isolated initiatives of an extremely experimental character were also taken, to deal with specific problems and to fight anaemia. Thus, I consider that, historically, Brazil launched its food and nutrition policy in great style by implementing the legislation that established the minimum wage."*

In his study on public policies regarding hunger in Brazil, Bonfim (2004) attempted to review the path followed by government activities.

The social nutrition project of the Brazilian State – although made up not of formal plans but rather isolated attempts until 1973 with the creation of the first National Food and Nutrition Program (PRONAN) – resulted from the rethinking of the economy between the 1930s and the 1940s when the Brazilian economy changed from its agricultural exports phase to the urban-industrial phase. The historic starting point for specific interventions in the area of nutrition in Brazil was the 1930s, as emphasized by Escoda (1983):

"(...) Within the populist context of the Vargas government, social policy experiments began to be implemented in this area. An example of this is the explicit concern of the State for the nutritional needs of 'adult workers' as represented by decree No. 399, of April 30, 1938"

The historical investigation carried out by Vasconcelos (2005) emphasized three key periods in the creation of a public agenda and public policies on the issue of food and nutrition. The first period – 1930 to 1963 – was when social policies regarding this issue first emerged. The greatest influence at the time was the studies of Josué de Castro. The second period – 1964 to 1984 – saw attempts to incorporate nutritional and economic planning techniques carried out by the National Food and Nutrition Institute (INAN). The third period – 1985 to 2003 (included in the study covered by the author) has been linked to attempts to democratize and modernize Brazilian society, as well as to search for alternatives.

Between 1940 and 1967, when the example of countries emerging from the deep structural and economic changes of the post-war period stimulated growth in Brazil, plans had to be developed to improve public nutrition in accordance with the development theory of the time. Thus, on August 5, 1940, the Federal Government, under decree No. 2478, created the Social Welfare Food Service (SAPS) whose primary goal was to ensure favourable and hygienic conditions to feed those insured by old-age pension institutions and funds governed by the Ministry of Labour, Industry and Commerce.

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

1. The first subsidized people's restaurants were opened in Rio de Janeiro, São Paulo and other cities in order to provide urban workers with balanced low-cost meals;

2. Food subsistence outlets were created to sell the basic necessities at subsidized cost.

3. Educational activities were implemented to encourage healthy eating habits and improve nutrition among the population;

4. Promotion of training courses, human resources development and the conducting of studies and research in this area (VASCONCELOS, 2005).

Among governments after 1940, the year SAPS was created, Gaspar Dutra [1946-1950] implemented the SALTE [health, food, transport and energy] Plan, Getúlio Vargas [1951-1954] brought back populism, Juscelino Kubitschek [1955-1960] launched the "National Development Plan," also known as the "Plano de metas" (Goal's plan) and João Goulart [1961- March 1964] implemented basic reforms. State intervention to support food and nutrition took the form of continuation of SAPS activities, the creation of the National School Meals Program (PNAE) in 1954, and the introduction of the nutritional care program for pregnant women, nursing mothers, and children under five, developed by the National Diet Commission (CNA) assigned to the Ministry of Health.

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

In the early 1960s, Rio Grande do Norte implemented a series of government nutrition programs. It was the Integrated Food and Nutrition Plan that initiated the multisectoral structure for nutritional planning, with a program made up of parallel components on health, education and food production. This program enjoyed broad participation within the populist tenor of the time, and its educational aspects were reinforced by the Paulo Freire method under the National Foundation of Public Health Services (FSESP) in an agreement with the state health and agriculture secretariats.

The Brazilian experience of official food and nutrition programs at the national level may be summarized with the following examples:

- SAPS (Social Welfare Food Service) was created in 1955 under the Café Filho Government. It provided a low-cost basic food supply to social welfare and pension recipients and contributed to the development of human resources specialized in nutrition, organizing courses for nutritionists in Rio de Janeiro. On September 26, 1962, under Law No. 6, SAPS became the Brazilian Food Supply Corporation (COBAL), a company responsible for "low cost" food supply through grocery stores designed to serve the general population.
- SNME (National School Snacks Service) was created by decree No. 37.106, of March 31, 1955, under the government of President Café Filho, for the purpose of supplementing school meals, at first with food donated from American surplus production. Law No. 480, of 1954 (Agricultural Trade Development and Assistance Act) established the standards for such surpluses. In 1974, the American Congress discontinued these donations, arguing that Brazil was already producing enough food for the country and had even won a contract to export soybeans to the United States. After that date, food of Brazilian origin was used for the school snacks. In 1967, SNME was renamed CNAE (National School Meals Commission), which continued developing the program to supplement school meals on a permanent basis. However, in December 1981, CNAE was transformed into the National Institute for Student Assistance (INAE), which took over the activities previously attributed to CNAE including the PRONAN Diet supplementation line.
- The National Food and Nutrition Institute (INAN) was created in 1972 during the Médici government (1970/1974) for the purpose of advising the government in formulating a food and nutrition policy. This agency was established by Law No. 5929, of November 30, 1972, and then converted into a self-governing entity linked to the Ministry of Health, by decree No. 73.996, of April 30, 1973. It operated as the principal support and coordination body in this area.

In summary, the period from the early 1940s to the first years of the 1960s saw progress towards a wider view of the food issue.

With the establishment of the dictatorship in 1964, the dialogue of social dissent regarding nutrition was replaced by a technical-scientific approach, justified by the terms rationality and efficiency. In fact, in 1964-1966 with the Economic Action Plan (PAE); in 1967-69 with the Strategic Development Plan (PED) and in 1970-72 with the Goals and Bases Plan for Government Activity, nutrition was no longer considered a specific item, but treated as a health-related problem.

The National Food and Nutrition Institute (INAN) and its Programs and Activities (1972-1984)

In 1972, the third Special Meeting of Health Ministers of the Americas was held in Santiago, Chile, with the goal of making changes in the way social policies were formulated in Latin America. This resulted in the development of the Ten-Year Plan for the Americas. The Brazilian government of the time was committed to the introduction of the main features of the food and nutrition policy. The Ten-Year Plan for the Americas signified a favourable political opportunity to include the issue of food and nutrition within the health context.

Due to the Ten-Year Plan for the Americas guidelines on food and nutrition, INAN was created as a self-governing entity associated with the Ministry of Health, replacing the National Food Commission.

INAN formalized the inclusion of diet and nutrition on the agenda in institutional terms, since studies at the time (ENDEF and PNSN) revealed high rates of infant mortality and malnutrition in Brazil. Among the objectives of INAN's creation were: i) to support the government in the formulation of the National Food and Nutrition Policy - PNAN; ii) to formulate and propose the National Food and Nutrition Program - PRONAN; iii) to promote implementation of PRONAN; iv) to supervise implementation of PRONAN; v) from time to time, to assess the results obtained; vi) to serve as a clearing house for food and nutrition activities in Brazil; and vii) to act as an agency for national development and security at the family level, breaking with the international systems that limited themselves to food distribution, which endangered Brazil's national security.

In 1973, PRONAN was created by decree No. 72.034, which remained in force until 1974. This was a set of 12 subprograms bringing together the various government structures at the federal level.

According to DINIZ (1988, p. 14-15), the main programs and projects achieved by PRONAN were: a) Complementary Food Program; b) Nutrition and Health Program, subsequently called Food Supplementation Program; and c) Program for the Rationalization of Food Production and Marketing , which brought together three specific projects: 1) Worker's Food Program (PAT); 2) National School Meals Program (food for preschool and primary school children); and 3) Preschool Child Support Program, which supplemented the nutrition of children between four and six years of age.

The logic of PRONAN was to consider food supplements as transitory, and as specific protection for the most vulnerable groups in society as well as support for small farmers. This would be the program's main activity, since 70% of Brazil's basic food production at that time was from these farm workers, who would have a guaranteed market and advance marketing of their products by the former COBAL. COBAL, in turn, would direct the surplus to the supplements.

Another of PRONAN's ventures created mechanisms to promote good nutrition among company workers and later rural workers ("bóias-frias"). A fourth venture would be the development of activities relating to the technology for enriching basic food products, as

specific protection measures to combat the leading nutritional deficiencies. It would also encourage nutritional research to investigate the nature of Brazil's nutrition problems and alternatives.

An important part of the empirical evidence determining the nature of PRONAN relates to the National Family Expenditures Study (ENDEF) of 1974-75. This research was performed with the goal of drawing the nutritional profile and mapping infant malnutrition. It was thus the first survey of the Brazilian population relating to food and nutrition, and revealed, among other things, the following:

> *"67% of Brazil's population had a daily energy intake lower than the necessary minimum stipulated by FAO. The Brazilian diet, while insufficient in terms of energy intake, was balanced with respect to other nutrients. 46.1% of children under five (56.5% in the Northeast region and 38.6% in South and Southeast regions) and 24.3% of adults exhibited protein-energy malnutrition (MOISÉS, 2001)."*

In 1975, a new administrative management was initiated at INAN, which decided to reach an agreement with the Institute of Economic and Applied Research (IPEA) to form a technical team to carry out studies on food and nutrition and define PRONAN II, conceived as a directive of the 2nd National Development Plan (PND II). This plan attempted to reformulate the government's social vision and activities in accordance with three principles: i) hierarchical equity between social and economic development; ii) special attention to low income groups; and iii) responsibility for solving social problems shared between the social and economic areas.

In 1974, with PND II, Brazil's public health took a great leap forward in the search for reorganization as part of the country modernization process. INAN developed specific food and nutrition programs, PRONAN I and PRONAN II, anticipating in a way the creation of a national policy in this area.

According to the testimony of one key informant:

> *"Since 1974, Brazil has had a formal diet and nutrition policy, formulated as part of PRONAN II, but it was curious there was a PRONAN II even though the first one had practically never existed, which is characteristic of our reality."*

This was a period of economic opportunity during which Brazil (1974/1975) was experiencing considerable economic progress and, at the same time, a terribly unfavourable social situation. Thus, for political reasons, including external ones, the World Bank granted a loan to Brazil, one explicit commitment of which was to deal with social issues such as infant mortality and malnutrition – both very prevalent in Brazil, as shown by the 1974/1975 studies.

Based on this requirement by international organizations and due to the social crisis and the military government's need for legitimacy, the National Food and Nutrition Policy was established within the health area under INAN's responsibility (although it was a sectoral agency within the health area with a multifactoral interdisciplinary approach involving various ministries). Also because, according to one key informant:

"INAN was a foreign body within the structure of the Ministry of Health. Therefore, it was decided to create a National Food and Nutrition Policy as a way of justifying the existence of this agency and as a way to institutionalize a commitment that should not be restricted to the health sector."

At that time, during the 1970s, great efforts were being made to rejuvenate the government's technical staff by training new personnel to deal with human health issues.

In 1976, the technical group from the health sector of the IPEA's National Human Resources Centre (CNRH) was placed in charge of formulating the second version of the National Food and Nutrition Program. Its main objective was to strengthen small and medium farms and develop precarious economic regions. Thus, PRONAN reflected an attempt to redirect health attention towards preventive practices with greater efficiency and social content, acting with the poorer groups, but with a wide range of age groups. According to Kruse (2004), the assumptions of PRONAN II were:

1. To give priority to users on the basis of their variable income (family income up to twice the minimum wage);

2. To give priority to age groups more vulnerable to nutritional deficiency (children, pregnant and nursing women);

3. To give preference to traditional foods;

4. To motivate small and medium rural producers; and

5. To prioritize activity in the Northeast region of Brazil.

Diniz (2001) states that this was a very broad governmental proposal that should be supported by coordinated action by various sectoral policies, including the areas of health and education, and not only by the traditional areas of food and nutrition.

According to Malaquias Batista and Barbosa (1985; apud DINIZ, 2001), the strategic functions of all PRONAN programs and projects were not supported by the economic policy in effect at that time, not to mention INAN's lack of political power to coordinate a broad sectoral policy in the areas of food and nutrition within PRONAN models.

In fact, by analysing the period of the military government, mainly the period comprising PND II, 1975 to 1978, we can see an expansion of social policies due to the government's need for legitimacy. Within PND II, social policy was used as a strategy to reallocate income. This comprised mainly three sectors: 1) Human Resources Development Program, including: education, health, sanitation, nutrition, employment and vocational training; 2) Social Integration - PIS, PASEP, Housing and Social Welfare; and 3) Urban Social Development (PEREIRA and PAIVA, 1981).

Therefore, during this period, social policy was expanded, backed up by programs and the respective implementation agencies, as demonstrated by Pereira and Paiva (1981). Among these are: the Employment Mediation Program (PIE) carried out through the National Employment System (SINE) in 1975; the National Rural Community Development

Program (PRODECOR) in 1976; the Urban Social Centres (CSUs) in 1975; PRONAN in 1976; the Program for Decentralization of Health and Sanitation Services (PIASS) in the Northeast in 1976; the Mother-Infant Health Program (PSMI) in 1977; the Preschool and Primary Students Service Program; the Child Welfare Program (PBEM) based on National Child Program (PNM) in 1977, among others.

In 1978, the International Conference on Primary Health Care held in Canada set out the eight basic features required to provide health for everyone: a) education on major health problems, prevention and control; b) promoting food supply and adequate nutrition; c) providing an adequate water supply and basic sanitation; d) mother-infant care, including family planning; e) immunization against the main infectious diseases; f) prevention and control of endemic diseases; g) adequate treatment of common diseases and accidents; and h) distribution of basic medications.

Thus, in the area of food and nutrition, PRONAN III, planned for 1982-1985, and suggested innovative measures such as the creation of a National Food and Nutrition Fund and the transformation of INAN into a public corporation, was never implemented: PRONAN II continued in existence until 1990, when it became virtually defunct (SILVA, 1995).

With respect to the analysis of the results achieved by these programs, we can infer that, since they did not go beyond mere charity work, they had a perverse effect, contributing to the maintenance of poverty and aggravating social inequalities, since they were mere palliatives offered by technical-bureaucratic complexes committed to the logic of accumulating social product (PEREIRA, 1987, PEREIRA and PAIVA, 1981).

To corroborate the above statement, Santos (1979) affirms that social policy in Brazil, at that time, was "inconsistent and segmented," since the so-called preventive policies (income, health, education, basic sanitation), rather than solving problems, contributed to intensifying them. What was required was the introduction of compensatory policies (social welfare, child welfare, food supplementation, etc.), which, however, were inadequate to meet all the demands, due to the magnitude of the social problems.

Democratic Transition and Food and Nutrition in Brazil: The Problem, the Agenda and the Alternative Solutions (1985-1989)

After this short review of the history of social policies in the previous periods, questions remain: after 1985, what was the social policy role of the Brazilian State during the period of democratic opening? What was the nature of the action in the area of food and nutrition during this period and what forms did it take?

In this short account, we do not intend to deal with the political, economic and social trends that resulted during the so-called New Republic. We will focus in particular on certain contradictions in this process with respect to social policies and their implications for the worsening contradictions of the 1990s, particularly in the area of food and nutrition.

In the New Republic government, priority was given to the social sphere, at least on the surface, as a way to redeem the social debt accumulated over two decades of military

government that had emphasized economic growth. The issues of citizenship, legal rights, political and social rights and the role of social policies as a strategy for combating poverty and reducing social inequality and a possible "common ground between capitalism and democracy" (OFFE, 1984) were at the heart of the debates.

Official documents set out the following objectives for social policies: *to eradicate absolute poverty, improve income distribution and reduce social inequality*. These objectives were combined in the creation of the emergency Social Priorities Program for 1985, with resources allocated to the areas of food, education, public health, security, urban infrastructure and housing. The main objective was to "make viable programs of a more immediate nature that are intended to kickstart efforts to fight poverty" (ABRANCHES, 1986, p. 84).

The Nutrition in Health Program (PNS), launched in 1975, proposed to distribute basic foodstuffs – rice, sugar, beans, cornmeal, manioc flour and milk powder – to pregnant women, nursing mothers, and children from low income families between six months and seven years of age, giving priority to poorer regions and providing 45% of their daily needs (SILVA, 1995).

In 1985, PNS was renamed Supplementary Food Program (PSA), with a target population of pregnant women, nursing mothers, and children under four. According to Silva (1995) the government's goal for 1986 was to reach 12 million beneficiaries throughout Brazil, and distribute 720,000 tonnes of food, as well as better integrate its services with health activity, with the goal of reducing infant mortality by 40% by 1990.

The foodstuffs making up the PSA's basic food basket were chosen on the basis of an earlier survey of food consumption conducted by ENDEF/FIBGE in 1975. This survey found that rice, beans, manioc flour, corn meal, milk and sugar comprised 80% of foodstuffs consumed by low-income families. The basic food basket was composed of rice, beans, milk and sugar in all regions. Manioc flour was added in the Northeastern region, and corn meal in the Southeastern, Centre-Western and Southern regions (DINIZ, 1988). PSA began to decline in 1987 and was replaced by the program called *Milk is Health* (SILVA, 1995).

Under the government of José Sarney, three programs gained prominence in the field of nutrition: a) the Supplementary Food Program (PSA) implemented by the National Food and Nutrition Program (PRONAN); b) the National Milk for Needy Children Program (PNLCC), implemented by the Community Activity Secretariat (SEAC) of the Presidency of the Republic; and c) the National School Meals Program (PNAE) implemented by the Student Welfare Foundation (FAE).

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

However, as noted by Vasconcelos (2005), between 1987 and 1989, in the economy resulting from the Cruzado, Bresser and Verão (Summer) Plans, a technical, financial and political hollowing out of food and nutrition programs was again observed.

By the end of the 1980s, five food and nutrition programs were still in operation: the National School Meals Program (PNAE); the Supplementary Food Program (PSA), the Complementary Food program (PCA); the National Milk for Needy Children Program (PNLCC) and the Worker's Food Program (PAT). In addition, there were still the complementary and support programs coordinated by INAN.

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

At this event, more than four thousand representatives of all segments of civil society discussed a new health model for Brazil, including the new framework of health as a right of the citizen, which was later confirmed by the Constitution of 1988. This was the event that synthesized the movement called the Brazilian Health Sector Reform, born during the struggle against the dictatorship and whose slogan was Health and Democracy. It was organized in the universities, the union movement and in regional experiments by service organizations (AROUCA, 1998).

The VIII Conference is considered a political watershed for the movement to democratize health, due to the efforts made by the organized social movements to explore issues around health-related topics.

When the debates ended, a consensus had been reached on the need to formulate a new health policy capable of contributing to and advancing the struggle for change in the system, beginning with the proposed creation of a Unified Health System based on the principles of universality, comprehensiveness and decentralization, under government coordination, although by means of social participation (RODRIGUES, 1995).

One of the greatest achievements of the VIII National Health Conference was to endorse the creation of the Unified Health System. According to Rodrigues (1995), the agenda for the Health Sector Reform Movement was based on the principles of decentralization, universality and equality of rights to health within the public system. The creation of a Unified Health System was a demand based on criticisms of the health policies management model of the 1970s such as the crisis in the health systems: inefficiency, ineffectiveness, inequity and a credibility crisis due to the demographic and epidemiological transition (aging and changes in nosological patterns, medicalization, technological development and rapidly expanding costs and expenses) (BUSS, 2005).

The centralization of the government's health sector policy led to a separation from the Social Welfare system, while, at the same time, regionalizing the management of services, emphasizing the public sector and providing universal service. On the other hand, a broader concept of health was being confirmed as a result of social, political and economic conditions.

Therefore, for the state councils, with the participation of more than four thousand State and civil society stakeholders interested in proposing changes in the area of public health, the VIII National Health Conference was a watershed in the history of health policy in Brazil and was an opportunity to suggest criteria to the National Constituent Assembly for reorganizing the National Health System. The central themes of this Conference were: a) health as an inherent right of citizenship; b) reformulation of the

National Health System in accordance with the principles of universality, participation and decentralization; c) organizational and institutional integration; d) redefinition of the institutional roles of political units (Union, states, territories and municipalities) in providing health services; and e) health sector funding.

After the conference ended, the National Health Reform Commission was created for the explicit purpose of analysing the difficulties identified in the operation of the national health services network, suggesting options for a new organizational structure for the system, by examining tools for linking government sectors acting in the health sector and proposing improvements, indicating mechanisms for multi-year planning in the sector and adapting them to the precise needs of the population sector to be served.

It was within this environment of ideas, values, corruption, conflicts and interests that, through the coming together of contradictory social forces within a climate of democratic transition, the National Constituent Assembly of 1988 was convened. The approval of the new Brazilian Federal Constitution was a major step forward on the road towards democracy and the legal, political and institutional reorganization of the country. The State, according to the constitutional text, became a Democratic State governed by Laws based on sovereignty, citizenship, human dignity, the social values of labour and free enterprise, and political pluralism (FC, 1997, Art. 1). The social rights of citizens are introduced in article 6 of the1988 Federal Constitution. These refer to social policies such as health, nutrition, education, employment, leisure, security, social welfare, protection of mothers and children, and assistance for the destitute.

In the area of social policy, the main achievement of the Constitution of 1988 was the inclusion of Social Welfare, made up of the three pillars of health, social security and social assistance, which became a right of the citizen, not as a "controlled citizenship" as in previous periods, in which citizens were only those with a defined occupation recognized by law (SANTOS, 1979).

Under the Federal Constitution, Social Welfare should be organized according to the following objectives: universal coverage and service; uniformity and equivalence of benefits and services granted to urban and rural populations; selectivity and distributivity in providing benefits and services; irreducibility of the value of benefits; equality in the form of participation in defraying costs; diversity in bases of financing; the democratic and decentralized character of administration, including participation by the community, especially workers, the business community, and retired persons. (FC, 1997, art. 194, single paragraph).

The principle of political and administrative decentralization goes beyond the design and implementation of social policies. A new federal covenant has thus come into existence according to which the Federal Government is responsible for coordinating social policies, and the states and municipalities are responsible for implementing them. The participation of civil society would be key in this process, as will democratic control over State activities in the area of social policy. According to Pereira (1998, pp. 121-122), achieving this political and administrative decentralization in the implementation of social policies must indeed allow for: "a) the establishment of new participatory practices; b) the combination of mechanisms of representative democracy (through political parties, unions, etc.) with mechanisms of participatory democracy (through

councils, commissions, etc.) needed to build the desired public space ." Thus, parity boards were established, tools to administer and control social policies, such as Children's and Young People's Rights Commissions, the Children's Social Services Commissions, the National Social Assistance Commissions, and Health Boards at all government levels.

The principles of the VIII Health Conference were incorporated into the Federal Constitution of 1988, on the basis of which the Unified Health System (SUS) was created, regulated by the Organic Health Law (LOS), Law No. 8080, 1990. The Intersectoral Commission on Diet and Nutrition (CIAN) of the National Health Council (CNS) was also created, with the aim of drafting and implementing the Food Security Policy (PSA), an initiative of the Ministry of Planning.

Analysis of the PNAN Formulation Process: Context, Ideas, Interests, Institutions and Policy Instruments

Political, Economic and Social Context of the PNAN Formulation Process (1990-1999)

Several decades of research on the factors that have influenced health over the years have led politicians to recognize as determinants various factors outside the health field, such as genetic make-up, socio-demographic situation, cultural beliefs, environmental conditions, and geographical and economic conditions in general.

The soundness of the research on health determinants has influenced the prevailing arguments on public health policies. For example, formulators of public health policy are paying more attention to developing processes for formulating policies that address the issues of vulnerable or marginalized groups with significant and complex health problems related to various causal factors.

Environmental factors such as emerging technologies and changes in the demographic profile of the population may also increase awareness of public health issues among the public, politicians and policy makers. These factors are prompting a gradual reassessment of the impact of an aging society on available resources. Since people are living longer healthier lives, assumptions regarding the nature and scope of public health programs and services needed to meet society's health demands are being challenged.

These and many other external factors have had an impact on how problems related to public health policies are understood. These factors also impact the combination of policy formulation tools that policy makers believe are appropriate for dealing with such problems (WELLER, 1980); ANGUS et al., 1995, EVANS and STODDART, 1994).

In Brazil's case, in 1989, the Ministry of Health organized the National Health and Nutrition Survey (PNSN), which revealed a decline in infant malnutrition compared with the National Family Expenditures Study (ENDEF) in the 1970s. Despite these results, differences were seen between Brazil's regions, the Northern and Northeastern regions being the most affected by infant malnutrition. Based on this work and the physical evidence of malnutrition so obvious to society at the time, a broad movement was organized to advocate formulation of a national policy for this sector.

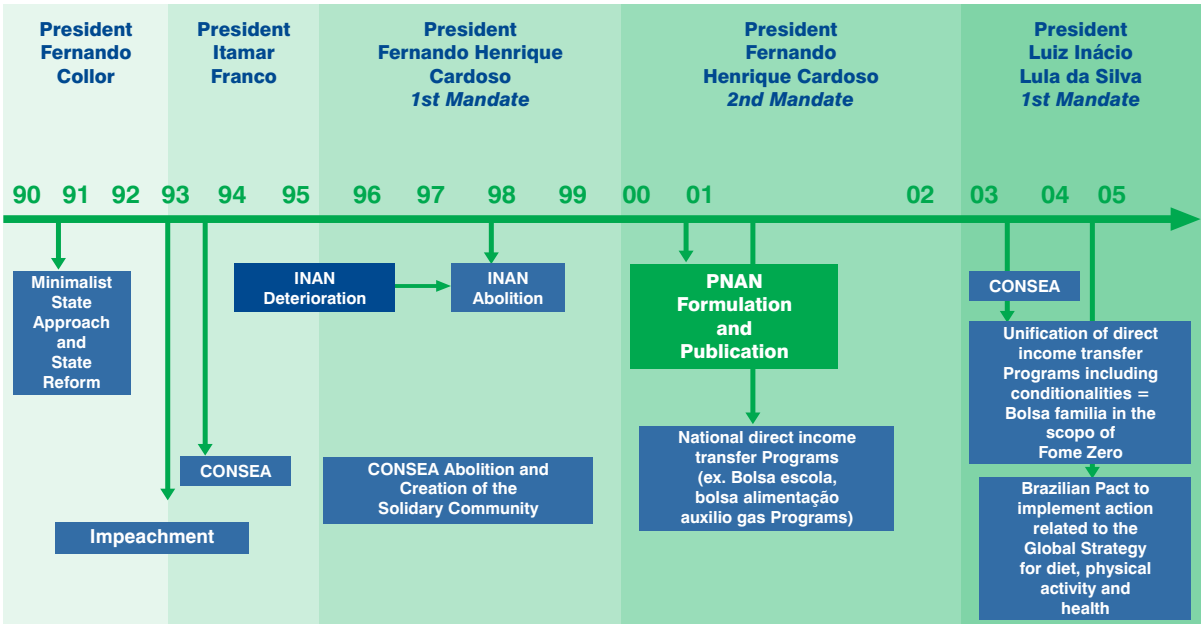
Frey (2000) argues that one of the most important components of public policy analysis is the "political cycle," due to the impermanent nature of sectoral policies, as is the case with the PNAN.

The Brazilian State's action in the area of food and nutrition has been changing in concept and administration, and in formulation and implementation processes, especially since the 1960s.

As will be seen in the analysis of the period from 1999 to 2005, the various phases in formulating and implementing PNAN action strategies over the period reveal a "very interesting heuristic model for studying the life of a public policy" (FREY, 2000, p. 226).

According to this author, the various phases correspond to a sequence of components of the political-administrative process, and may be investigated with respect to the constellations of power, political and social networks, and political-administrative practices typically observed in each context, as follows:

Historical Context of PNAN Formulation



The Collor Government: State Reform and Food and Nutrition Programs

1990, a year that changed the history of Brazil, saw the first democratic election of the president since the dictatorship (established in 1964). On the other hand, there was a contradiction in that government, the more progress the country made in consolidating democracy, the closer it moved towards implementation of neoliberal ideas for State reform. Discussions on economic stability and modernizing the State and the economy were combined with reductions in financial resources, the hollowing out of social programs and abolition of public agencies (VASCONCELOS, 2005).

Fernando Collor de Mello's election was strongly influenced by the mass media. Inflation of over 80% a month was ravaging people's savings. This evil had to be stopped.

Protected by the naivety of the Brazilian people and with unquestioned support from famous economists, Collor became the advocate of "neoliberalism", announcing privatizations and dismissals of thousands of public servants all over Brazil. After that, great difficulties had to be overcome to achieve real democracy. National maturity was still far off. The announced economic plan confiscated savings accounts, checking accounts and financial investments.

In 1991, the return of inflation was relentless, and was attacked with high interest rates, with the resulting recession, cooling of the economy, and increasing unemployment.

In 1992, the press revealed a vast network of government corruption. Civil society organized, and formulated a "Manifesto for Ethics in Politics," which found support in all states of the federation. Brazil's young people created the so-called "painted faces" movement, and entered the political scene. Indignation seized the country.

On September 1, 1992, the Brazilian Bar Association (OAB) organized a historic march to the National Congress carrying a petition for impeachment of the President. This petition was based on increasingly damaging accusations carried in the national media.

The President counterattacked. He called on the people to take to the streets. On September 16, 1992, the people complied, carrying signs, blowing horns, staging protest parades and wearing black to protest against the demands of the Executive Power and the National Congress.

On September 29 of that year, proceedings were instituted to impeach the President of the Republic. He was immediately removed from power, and Vice President Itamar Franco took over. Proceedings lasted for three months. On December 29, 1992, during hearings before the Federal Senate, Collor resigned and had his political rights suspended for eight years.

The areas of food and nutrition were also included in the reforms carried out during the Collor period. As Valente observes (2001), this government reorganized the political agencies and instruments concerned with health and nutrition, eliminating food supplement programs designed to help children under five year of age and cutting back on other programs, such as the National School Meals Program (PNAE), the Worker's Food Program (PAT) and the National Food and Nutrition Institute (INAN).

Again according to Valente (2001), the only positive aspect of that period was the initiative to use public food stockpiles for food programs, an old demand of technicians aimed at reducing the waste of regulatory stockpiles. This resulted in the creation of the program of basic food baskets for distribution to the population suffering from the drought in the Northeastern region in 1990. In March of that year, a representative from the Brazilian Association of the Nutrition Industry (ABIN) was appointed President of INAN and his administration prioritized substituting industrialized products for traditional basic foodstuffs.

One key informant reminds us that most of the official documents on food and nutrition programs from this period, 1990 to 1992, even those from previous administrations, were destroyed. These included food supply programs, food and nutrition programs, and

even those targeting the vulnerable group of children under five. Other programs were gradually suspended and left inactive, as was the case with the National School Meals Program (PNAE).

Even while these social programs were being rendered ineffective in the 1990s, the Collor government ratified the International Convention on Children's Rights. In the Multi-Year Plan (1992-95), children and adolescents were among the Government's five main priorities. Nevertheless, what was seen in practice was a complete hollowing out of social programs, especially food and nutrition programs targeting the mothers and infants. In previous years, food and nutrition programs had represented ways of reducing hunger and malnutrition, especially among children and pregnant women. However, these programs were gradually being hollowed out, since the financial resources allocated were far less than what was needed to meet the announced targets.

PSA targeted pregnant women, nursing mothers and children under 36 months from families with a monthly income of less than two minimum wages. PSA's goal was to distribute 378 thousand tonnes/year to 6.7 million beneficiaries; however, it distributed only 60,401 and 36,484 tonnes of foodstuffs in 1990 and 1991, respectively.

The Nutrition Support Program (PAN), targeting pregnant women, nursing mothers and children between 6 and 36 months, suffered a 45% reduction in coverage compared with 1978.

The National Milk for Needy Children Program (PNLCC) aimed at families with children under seven and under the auspices of the Ministry of Social Activities was suspended in 1991.

Also according to Escoda, Vilar and Begin (1992), in addition to the problems of cutbacks in resources invested in this area, these programs never questioned the reversibility of the social roots of hunger and malnutrition. Throughout, they had very low coverage and a low nutritional impact, producing regional and social inequality. Coverage was better in the more developed regions (South and Southeast) than in the poorer regions (North and Northeast). Furthermore, the immediate palliative responses of these programs were aimed at legitimizing the state/government, especially during election campaigns or times of intense social tumult.

The following table illustrates the components of the National Food and Nutrition Program in effect during the Collor government from 1990 to 1992 (SILVA, 1995).

Table 1: ***PRONAN Components Maintained during the Period 1990-1992***

Program	Results	1990	1991	1992
PNAE (1)	Population Served	29,680,968	29,065,000	30,600,000
	Foodstuff Distributed (tonnes)	138,116	134,685	92,918
PSA	Population Served	6,667,000	6,667,000	2,786,000
	Foodstuff Distributed (tonnes)	60,401	36,484	2,899 (2)
PCA/PAN	Population Served	1,078,000	-	-
	Foodstuff Distributed (tonnes)	11,398 (3)	-	-
PNLCC	Population Served	7,818,000	-	-
	Foodstuffs Distributed (tonnes)	1,157,316	-	-
PAT	Population Served	6,431,693	6,822,917	7,847,413
	Companies Participating	33,999	37,751	42,213
PNIAM	Activity reduced during the period; coordination by IHAC beginning 1991			
Preventing Anaemia and Hypovit. A	Almost completely interrupted.			
PCBE	Reduction in the acquisition of potassium iodate; inquiries in the *sentinel areas* suspended.			

(1) Includes PAIE, which, in 1990, received 17.8% of the food stuffs distributed;
(2) Milk powder with resources from the defunct PNLCC;
(3) In addition to the 1.6 million basic baskets acquired in the last month of the year.

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

After the impeachment of Fernando Collor, initiatives from civil society led to the establishment of CONSEA on April 24, 1993, by decree No. 807, during the government of Itamar Franco. This council was made up of one third government members and two thirds members of civil society.

Among many events between 1990 and 1992 motivated by government excesses, the lack of social policies and the resultant increased poverty and hunger prevailing in the country, a struggle arose for citizen's rights, which culminated in the Movement for Ethics in Politics and the Citizens' Campaign Against Hunger and Poverty and For Life.

During the government of Itamar Franco (1993-1994), the National Council for Food Security and Nutrition (CONSEA) was created. The proposal had been suggested to the Collor government, which had not moved on it. In February 1993, it was presented again to the new president, Itamar Franco, who, in the end, supported the establishment of the National Plan to Fight Hunger and Poverty, as well as the creation of CONSEA in May of the same year. This was the first effective partnership between civil society, through the movement lead by Hebert "Betinho" de Souza, the Citizens' Campaign against Hunger and Poverty and For Life, and the public authorities, which made it possible to launch a remarkable phase of mobilization in the country. From this time on, confronting hunger and poverty became an issue discussed in the context of economic and social policy and food and nutrition security, with continuous debate between civil society and the State. CONSEA proposed the Emergency Diet Distribution Program (PRODEA) as a response to the Hunger Map released by IPEA in 1993. (LAGE, 2006)

Between 1990 and 1992, the struggle for citizens' rights, with as leading stakeholders the Movement for Ethics in Politics and the Citizens' Campaign against Hunger and Poverty and For Life, organized solidarity and emergency actions throughout the country. However, the philanthropic aspect of food donations was the main, if not the

only, reaction to the problem of hunger and poverty, and the solidarity aspects (such as participation and support for social movements) was reduced to the "assistance and volunteerism" model, and dissociated from criticism regarding the social production of hunger.

Through Betinho's committed militancy, the discussion of citizens' action against hunger and poverty increased, and sentiments were strengthened within various social sectors regarding the urgent nature of agrarian reform and the need to refocus food supply policies.

Despite the brief experience during the period 1993-1994, CONSEA brought the discussion about hunger and considerations of food security inside official circles. During this period, although there were only a few programs and institutions, food and nutrition issues worked in favour of the rationalization sought at the end of the 1980s.

CONSEA's objectives were: a) to establish guidelines for the Plan to Combat Hunger and Poverty; b) to design an adequate strategy for its implementation; c) to mobilize the resources needed to attain these objectives; d) to promote partnership and integration between public and private and national and international agencies, with a view to guaranteeing the mobilization and rationalization of the use of resources, as well as complementarity in the actions taken; e) to coordinate public awareness campaigns against hunger and poverty, with the goal of bringing together government and societal efforts; and f) to encourage 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 Diet Distribution Program (PRODEA) in reaction to the empirical evidence generated by the Hunger Map (IPEA, 1993) as well as by the call to social action by citizens to support emergency food distribution. However, even though the practice of distributing basic food baskets was nothing new in Brazil, at the time it was harshly criticized by public opinion, mainly because of its welfare nature, disconnected from determining factors such as the economic, social, political and cultural inequalities that create poverty, misery and hunger in the country.

On an initiative by the CONSEA, in July 1994, the first National Conference on Food and Nutrition Security (CNSAN I) was organized. The "political community" that took part in CNSAN I strengthened the concept of food security as a guarantee of universal access to food of good nutritional quality.

This first conference resulted from a process of national social mobilization around the "food issue" and from awareness of the growing hunger in Brazil. A political declaration and a program document were also produced with the conditions and requirements for a National Food and Nutrition Security Policy (MALUF, MENEZES and VALENTE, 1996).

The main results produced by CNSAN I were: a) broadening the conditions for access to food and reducing its weight in the family budget; b) guaranteeing health, nutrition and food for specific groups in the population (at nutritional or social risk); c) guaranteeing the biological, hygienic, nutritional and technological quality of foodstuffs and their use; and d) encouraging healthy eating habits and a healthy lifestyle.

From National Council for Food Security and Nutrition (CONSEA) to Community Solidarity (1995-2002)

In 1995, Fernando Henrique Cardoso (FHC) took office as President of the Republic. One of his first political measures in the field of social policy was to abolish CONSEA and replace it with the Community Solidarity Program, focusing on combating hunger in the municipalities.

The Community Solidarity Program (PCS) was governed by federal decree No. 1366 of January 12, 1995, with the aim of *"coordinating government action to serve that portion of the population who do not have the resources needed to meet their basic needs and, in particular, to fight hunger and poverty"* (SILVA et al., 2001, p. 72).

PCS embodied a federal government strategy to coordinate activity by civil society and the State in all government spheres (federal, state and municipal), as well as the integration of federal initiatives within the municipalities with the greatest concentration of poverty in Brazil at the time.

Put forward as an alternative to reformulate the institutional design of the Itamar Franco government's Plan to Combat Hunger and Poverty and for Life (PCFM), which was coordinated by the National Council for Food Security and Nutrition (CONSEA), PCS's goal was to "increase the efficiency and effectiveness of government action without putting greater pressure on public spending. 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 activities were: a) reducing infant mortality; b) food; c) support for elementary education; d) urban development; e) creation of employment and income; and f) occupational skills.

There was a great deal of criticism of the assistencialism that prevailed in the activities of the Community Solidarity Program (PCS) as a strategy for dealing with poverty at that time.

The first referred to the disconnect between these activities and the structural distortions present in Brazilian society (CAMPOS, 1995, apud SILVA et al. 2001, p. 76).

The second criticism focused on the PCS as a federal government strategy of transferring responsibility for social policies to civil society. Solidarity was used as a justification, but this led to fragmented, selective and narrowly focused action (QUEIROZ and MATSUBARA, 1995, apud SILVA et al., 2001, pp. 76-77).

The third criticism referred to the neoliberal nature of the Program, in accordance with Sposati's arguments (1995, cited by Silva et al. 2001, p. 77), among which we may mention: a) abolition of social assistance agencies, shedding public responsibility for social policies; b) emphasis on centralization of the federal executive, even while preaching decentralization of action in the states and municipalities; c) failure to specify resources dependent on different ministries, and allocating them to different programs, conferring on them a lack of stability; d) narrowly focused and selective action; and e) a return to traditional paternalistic practices.

In 1996, the international situation was extremely favourable in the area of food and nutrition. In that year, the United Nations Food and Agriculture Organization (FAO) organized the World Food Summit in Rome. This conference placed the focus on food as a human right on international and national public agendas. New information was released showing that issues relating to nutrition were downplayed in politics and needed to be publicized in order to produce an institutional reaction.

Taking advantage of the opportunity provided by the World Food Summit, discussions of the need for Brazil to formulate a National Food and Nutrition Policy (PNAN) gained strength, especially with the mobilization of a small group of technicians from the former INAN, abolished in 1997, which succeeded in getting this issue on the sectoral agenda of the Ministry of Health.

These discussions were encouraging and strengthened the technicians' group, and the concept and necessity of work on the intersectoral nature of the issue, mainly within the context of combating infant mortality and malnutrition in Brazil.

However, with the abolition of INAN, the path to policy formulation was interrupted – while attempts were being made to include this policy on the agenda of the Ministry of Health, - in the early 1990s, when almost all food and nutrition programs were abolished by the government of the time.

Spurred by international organizations working on food and nutrition issues with an approach targeting food and nutrition security, INAN - suffering from dissent and corruption –faced timid discussions about the unprecedented spread of chronic disease. Such discussions also took place in the Ministry of Health, more specifically in the area of diabetes and hypertension coordination, where indicators from surveys carried out in Brazil were being considered. These were not sufficient to translate the confrontation of this issue into action.

For Valente (2002), from the point of view of the FHC government, the confrontation with the food and nutrition security issue disappeared from the political agenda, even while some action continued to be supported by the Community Solidarity Executive Secretariat in a partnership with civil society involved in the struggle for food and nutrition security. This included: a) the effort to prepare and monitor the Food Security budget; b) preparations for the World Food Summit, which began at the end of 1995 and was concluded in June 1996; c) the effort to monitor compliance with the resolutions of the World Food Summit (Rome, 1996) at the national level; d) the organization of a Food Security Data Base in partnership with IPEA.

The priority given to food security by the FHC government may be measured, to some extent, by the efforts mentioned above. Among them, the preparation of the Brazilian document for the World Food Summit (1996) stands out. During this process, the public debate on food security resumed and the Human Right to Food was included in the document as one of the commitments of Brazilian society. The debate also made clear the gap existing between proposals from the government economic area and those from the social sectors involved.

The work of the Executive Secretariat of the Community Solidarity Program (PCS) – also according to Valente (2002) – became increasingly remote from civil society. However, it is important to recognize that it was transformed into an interesting tool for coordinating government social activity, even though it had no power to interfere in the management of economic policies or even in the broadest definitions of social policies.

Its efforts were aimed at fighting hunger, poverty and social exclusion in Brazil, by improving the efficiency and effectiveness of social programs for the poorest segments of Brazil's population (IPEA, 1998). The Secretariat acted on the basis of the principles of solidarity, decentralization, partnership, and focus and convergence of action. The work was concentrated in the country's poorest municipalities, and 20 programs from nine Ministries were chosen to make up the basic agenda. The proposal established that these municipalities would be given a seal of priority to encourage differentiated allocation of resources to them.

One of the most complex tasks undertaken by the Executive Secretariat of the Community Solidarity Program (PCS) was to coordinate the Emergency Diet Distribution Program (PRODEA), which began in 1995. This program, created for an emergency situation, was later transformed into a permanent social program, due to the absence of structural action or social policies that could replace it (VALENTE, 2002).

During President Fernando Henrique Cardoso's second term, which began in 1998, some changes were made to the Community Solidarity Program (PCS), with the introduction, in January 1999, of the Sustainable Integrated Local Development Plan, also called the Active Community Program. This became the Secretariat's main strategy for fighting poverty and, from its beginning, showed its intention of not working specifically with hunger and malnutrition, and even less with food security. As a consequence, PRODEA was abolished by the end of 2000.

During this period, one of the few government areas to continue effective discussions on food and nutrition within a food security perspective was the Ministry of Health's recently created Food and Nutrition Technical Sector (ATAN).

In 1999, after a broad debate with civil society, the National Health Council approved the new National Food and Nutrition Policy (PNAN), which became part of the perspective of promoting the Human Right to Food and affirmed the need to frame a broad policy on Food and Nutrition Security.

As a way of instituting PNAN, the Ministry of Health's Food and Nutrition Technical Sector received political support from the sector and the government to implement the Food Basket Program. This program would in a way replace PRODEA with respect to its nutritional aspects aimed at children and pregnant women from poor families.

Thus, the two last years of the FHC government were marked by the absence of a coherent social policy due to the collapse and fragmentation of initiatives in the sectoral areas of Health, Education, Agriculture and Supply, Employment and Planning. A Basic Agenda was drawn up, and implemented by the municipalities through agreements reached with the respective Ministries in accordance with the following table:

Table 2: ***Programs of the Basic Community Solidarity Agenda by Area of Activity and Ministry Responsible***

Area	Program	Ministry
1. Reduction of Infant Mortality	a) Program to Combat Infant Malnutrition b) Mother-Infant Coordination c) National Immunization Program d) Community Health Agents Program (PACS) e) Basic Sanitation Action	Ministry of Health
2. Food	a) National School Meals Program (PNAE) b) Emergency Diet Distribution Program (PRODEA)	Ministry of Education, Ministry of Agriculture, Livestock and Supply
3. Support for Elementary Education	a) Basic School Materials Grant – Basic Basket (student, teacher, school) b) Student Health Program c) National Student Transportation Program d) Early Childhood Education Program	Ministry of Education
4. Support for Family Farms	a) National Program to Strengthen Family Agriculture (PRONAF)	Ministry for Agriculture, Livestock and Supply
5. Creation of Employment and Income; Occupational Skills	a) Program for Creation of Employment and Income (PROGER) b) National Program for Vocational Education (PLANFOR) c) Program for Occupational Skills - Employment Agency	Ministry of Labour
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)*

In this context, the issue of Food and Nutrition Security found no support within government. Initiatives to articulate a food and nutrition security policy were completely undone.

Reviving Food and Nutrition Security as a Government Priority (2003-2005)

When Luiz Inácio Lula da Silva became President in January 2003, he placed hunger eradication and poverty on the government's public agenda, and made it an absolute priority for his mandate. He therefore launched the Program called "Zero Hunger" immediately in 2003 as his government's main strategy, expressed in the Multi-year Development Plan (MYP) for 2004-2007.

The objective of the Zero Hunger Program was to combat the structural causes of hunger and poverty, as well as to ensure that *there would be food on the tables of those who most needed it*. This Program thus promotes the idea that citizens have a right to quality food.

The Program proposes to eradicate hunger for 44 million people with incomes of less than a dollar a day and will therefore require enhancement of structural policies: creation of jobs and increased incomes, strengthening of agrarian reform; universal social welfare; family allowance, minimum income and incentives for family farming. The Program also includes complementary policies, such as: Food Coupons; expansion and re-orientation of the Worker's Food Program (PAT); donation of emergency basic food baskets, management of mother and child malnutrition; maintenance of security stockpiles; increase in school snack programs, guarantee of food safety and quality, creation of programs for nutrition education and consumer education and several other local policies.

In the field of social protection, the government decided to bring together all of the previous government's income transfer programs, such as the cooking gas allowance, school grant and food basket. They were included in a single program called Family Allowance, under the so-called Special Ministry for Food Security, which is now the Ministry of Social Development and Hunger Eradication (MDS). The Family Allowance Program was designed on the basis of criticisms of the Zero Hunger Program, and showed a government's ability to react when it is trying to find the missing link in social policy. Within this logic, while the Zero Hunger Program was a State action that mobilized society, the Family Allowance, as a government program, promoted the search for a rational application of public resources in the social area (NÉRI, 2005).

The efforts under the Zero Hunger Program were to involve several sectors, such as Agriculture, Health, Education and Planning and civil society. Food and nutrition activities developed within the sphere of the Ministry of Health are based on the National Food and Nutrition Policy (PNAN). Responsibility for implementing this policy falls upon the General Food and Nutrition Policy Coordinator (CGPAN), at the time linked to the Health Policies Secretariat, now called the Health Service Secretariat (SAS), within the structure of the Ministry of Health. Democratic control is exerted by the Intersectoral Commission on Food and Nutrition (CIAN) of the National Health Council (CNS).

With the introduction of the Global Strategy on Diet, Physical Activity and Health proposed by international organizations, PAHO, WHO and FAO, and ratified by the Brazilian government in 2004, major decisive action was initiated within the Ministry of Health to deal with the issue of food and nutrition, although in fragmented and conceptually scattered fashion.

Again in 2004, with the return of CONSEA as the centrepiece of the Zero Hunger Program, the second National Conference on Food and Nutrition Security (CNSAN II) was held in Olinda (PE), ten years after CNSAN I.

Deliberations at CNSAN II included proposals for strategic action for a national food and nutrition security policy and 19 motions on various issues relating to food and nutrition security in Brazil and around the world.

The debates that took place within the issue groups and plenaries as well as the proposals approved, reaffirmed the main principles that must be associated with food and nutrition security and be considered in public action and policies aimed at promoting them. These are: a) adopting promotion of the human right to healthy food, making food and nutrition security permanent strategic objectives associated with food sovereignty; b) ensuring universal access to quality food, especially by creating employment and income and contemplating educational activities; c) seeking transversality in efforts through intersectoral joint planning and social participation; d) respecting gender and ethnic equality, recognizing diversity and valuing nutritional cultures; e) promoting family farming based on agroecology, together with sustainable use of natural resources and protection of the environment; and f) recognizing water as a essential nutrient and as public property.

These principles govern the national food and nutrition security policy. They constitute references that confer meaning and organization on 153 strategic activity proposals approved by CNSAN II, 47 of which were defined as priorities (CONSEA, 2004).

Ideas

Ideas represent information that policy makers use to recognize a public health problem and decide on the best way to act. Personal values are an important source of information for politicians in formulating public policies.

In the area of health promotion, recent research in Canada and the United States suggests that the personal convictions of policy makers regarding the government's role in promoting healthy behaviour are a significant factor influencing their support for tobacco control legislation in particular, and health promotion policies in general. We also know that discussions on many health promotion/disease prevention issues revolve around values regarding personal choice and not public safety (COHEN, et al., 2002).

Public policies are also formulated on the basis of empirical evidence produced by researchers from universities and research institutions, both public and private. Each of these centres, as it conducts surveys, is influenced by its own set of values when gathering and analysing information. For example, there are research institutions with left-wing political tendencies that present a given perspective on an issue and institutions with right-wing political tendencies that provide a different perspective. The information from these institutions may be used by governments in different states, according to the ideological alignment most appropriate at a given time.

The third source of information for policy makers is conversations held with the general public or representatives of various interest groups. Although informal and unscientific, this source of information is considered extremely important in influencing the positions of policy makers.

A fourth source of information is public opinion surveys. Governments are increasingly using this method to obtain information on the public's preferences regarding the main political issues. This kind of research is a more scientific way of determining citizens' opinion than personal meetings and informal conversations. Some people claim that public opinion surveyors have became the most important source of information for those responsible for political decisions.

Most of the information sources described above are filtered by the popular media, including newspapers, magazines, radio and television, before reaching decision-makers and the general public. The way an issue is presented by the popular media may have a significant impact on public opinion and the choices policy makers make when formulating a specific issue. If the media do not recognize the existence of an issue, the government may not feel compelled to do anything about it.

At any given moment, certain generalized ideas on public policies will be widely shared and form a basis for discussing policies. This may coincide with a broad basic public consensus on a national issue (the nation's mood). But ideas supported by policy makers and the general public today may be abandoned at some time in the future. However, ideas on policies may reach the discussion point depending on the circumstances. Once this point is reached, policy makers either turn the ideas into policies or reject them. Finally, the way problems relating to policies are defined and the values that receive

preferential treatment are factors that greatly influence the solutions considered and chosen.

Ideas and values go beyond the elaboration of public policies. This occurs because public policies define not only government discourse, but also government action. A public policy may also be defined as a set of decisions made in response to a given social problem. After all, as political beings, we are making decisions all the time: "deciding that there is a problem; deciding that it is necessary to try to solve this problem; deciding on the best way to solve problems; deciding to legislate on the subject" (SUBIRATS, 1994, p. 41). In order to understand public policies, they must be considered as a process that involves a flow of interactions between the stakeholders involved in the development, implementation and assessment of public policies. The decisions imply, on the other hand, value judgements, ideas, interests and conflicts that are processed in an institutional setting.

To understand the process of public policy formulation, we need to understand the characteristics of the stakeholders: what institutions they represent, what roles they play, what authority they represent or enjoy, how they relate to and control one another (LINDBLOM, 1991, p. 11) and, above all, what interests, ideas and institutions they defend. We know that the stakeholders involved and interested in the process of public policy formulation do not always agree completely on the problems, the alternative solutions or the alternatives chosen.

There are various interpretations of the problems and alternatives. There is a cycle of negotiation, consultation and even imposing decisions and, finally, different formalities, strategies and opportunities to expedite an issue on the public agenda, including the dissemination of new ideas and values on the design of public policies.

The participative democratic process of public policy formulation implies negotiations between different ideas and points of view that may or may not lead to rational agreements, such as the standardization of the National Food and Nutrition Policy (PNAN).

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

According to these authors, the present current of public policy analysis developed after 1980 as an effort to understand public policies as cognitive and normative matrices representing the reality within which public and private stakeholders could take action. This is, therefore, an approach that establishes the importance of dynamics in the social construction of reality to determine socially legitimate frameworks and practices in a given situation as understood by Berger and Luckmann (1986, apud MULLER and SUREL, 1998).

Thus, how were the ideas and values of various stakeholders of the State, society and the market incorporated into the text of the National Food and Nutrition Policy? How

were these ideas shaped? Would these be social formulations of the reality regarding problems and solutions relating to food and nutrition in Brazil? How did this process occur? How did these stakeholders negotiate, consult, persuade and argue regarding the ideas and values?

Formulation of PNAN began embryonically in the 1970s with studies and programs conducted and/or coordinated by INAN, the agency responsible for efforts in the food and nutrition areas, under the administration of Dr. Bertoldo Cruze Grande de Arruda, as pointed out by one key informant.

The main national studies that supported PNAN formulation were the following:

National Family Expenditures Study (ENDEF)

Carried out between 1974 and 1975, ENDEF was a door-to-door survey, national in scope (except for rural areas in the North and Centre-West regions), and took an entire year to collect the data. ENDEF was carried out by the Brazilian Institute of Geography and Statistics Foundation (FIBGE) with the aim of collecting relevant data on family budgets and food consumption. Its main focus was to analyse the nutritional situation on the basis of a tabulation of family budgets. It was already accepted that poverty was the main cause of malnutrition, but it was urgent and essential to know the distribution of family budgets, family priorities and the percentage of family income spent on food.

With a large sample, some 55 thousand households and data from approximately 53 thousand families, ENDEF was one of the most complex (difficult and highly invasive) and expensive surveys ever carried out in Brazil. Its sampling design had to be adapted to a number of analysis needs, such as providing substantive information to 22 geographic strata: nine metropolitan regions – Urban Areas in seven regions (Rio de Janeiro; São Paulo; Southern macro region; Minas Gerais and Espírito Santo; Northeastern macro region; Northern macro region; and Mato Grosso and Goiás) – Brasilia and – Rural Areas in five regions (Rio de Janeiro; São Paulo; South region; Minas Gerais and Espírito Santo; and Northeastern region).

Another unique feature of this study was the inclusion of the methodology to weigh food, which, in order to make the research viable and to reduce costs, had to be performed in two households at almost the same time. For this procedure to be possible, it was decided in the sampling selection to always choose pairs of neighbouring houses. This reduced the time required for the interviewer to travel from one place to another and allowed for data collection in two households per interviewer per week.

The research methodology applied by ENDEF consisted in conducting interviews in each home over seven consecutive days. Such a procedure allowed the interviewer to see the variation in food consumption over a whole week, including typical weekend fare.

In addition to this information on food in the homes, other socio-economic data were also collected such as family composition (sex, age, migration and relationship of all family members to the head of the household), employment and income. Anthropometric data on the residents were also collected, as well as complementary information such as presence during meal times and special eating conditions.

In order to calculate the family's annual expenditures on food, the researchers extrapolated these data on food actually consumed to the whole year (all 365 days). This adds a special feature to this study: the possibility of separating monetary and non-monetary expenditures on food. Non-monetary expenditures refers to foodstuffs obtained through family production, hunting, fishing, harvesting, trading, donations received and food taken out of the business managed by the family or obtained as payment for services rendered.

National Health and Nutrition Survey (PNSN)

This survey was carried out by INAN (National Food and Nutrition Institute) in cooperation with IPLAN and FIBGE. It was carried out using a nationwide sample of households similar to the PNAD (National Household Sample Survey), which allowed use of IBGE supervisory and field teams in the research. The sample was made up of 17,920 homes throughout the country.

The PNSN sampling plan was designed to provide estimates representative of the Brazilian population living in private and group homes. This definition excludes the institutional population living in group homes and those residing in aboriginal settlements. For this survey, 498 field teams were trained to record the height and weight of the 62,000 persons interviewed. The anthropometric measurements and the questionnaire used made it possible to gauge the nutritional and general health of the interviewees. Information was also collected from various strata of the population on the various food and nutrition programs, as well as issues regarding breastfeeding, sanitation, characteristics of the home, income, occupation and other variables. These data made it possible to interpret the nutritional pictures found in terms of their socio-economic determinants. The survey took two and a half months and the fieldwork was conducted between July 3 and September 15, 1989.

All the data generated by the PNSN made it possible to formulate diagnoses representative of the population for the nine domains indicated by the rural and urban areas in the five Brazilian macro regions (except the rural North).

Preliminary data from this research were published in March 1990 and included analysed data on children under ten. The second report on the research, published in September 1990, covered aspects relating to the growth of the population between 0 and 25 years of age. The third report, released in September 1991, analysed the nutritional conditions of adults and the elderly in Brazil.

Demography and Health Surveys (PNDS)

Conducted by BEMFAM (Brazilian Family Welfare Society) in 1996, this is part of the worldwide Demographic and Health Surveys (DHS) Program. There were other two editions, in 1991 in the Northeast region, and in 1986 nationwide. The Demography and Health Surveys work with national/regional representative samples for women between 15 and 49 years of age and are designed to provide information on fertility, mother-infant health and socioeconomic characteristics of the population interviewed. In the area of fertility, the information collected made it possible to assess fertility levels and trends, knowledge and use of contraception methods, breastfeeding and other determinants of fertility, such as proportion of women married and/or living with a partner and duration

of post-delivery amenorrhea. It also investigated reproduction intentions and unsatisfied needs with respect to family planning.

In the area of mother-infant health, information was collected on maternal mortality rates, STDs/AIDS, pregnancy, and prenatal and childbirth care. With respect to children's health, the data collected make it possible to determine infant and child mortality rates and trends and also to analyse their socioeconomic determinants. The main causes of the predominant child diseases (diarrhoea and respiratory infections) were investigated as well as immunization, nutritional conditions, and access to clean water and sewers.

The survey also recorded the socioeconomic characteristics of the population interviewed, such as age, education, access to communication media, occupation, colour, religion, the household's situation in relation to access to clean water, sewers, electricity, durable consumer goods, number of rooms and the principal construction materials used in roofs, walls and floors.

In its 1996 version, in addition to the survey of the female population, a smaller sample of 25% of households was selected for a survey of the male population. This was an attempt to analyse information on knowledge, attitudes and practices related to family planning, reproductive intentions and AIDS-related knowledge and sexual behaviour from the male perspective.

The survey began in September 1995, with the creation of an Advisory Committee made up of public and private institutions active in the production, analysis and disclosure of health and demographic data in Brazil. The committee's participation contributed to discussions of questionnaire contents and sample size, assessment of the analysis plan and disclosure of survey results. The research also received cooperation from FIBGE for samples selection (PNAD model) and the participation of technicians during the field team training phase and for data input.

With respect to ideas and values, policy assumptions were included on the basis of the assumptions defined and agreed upon in the document presented by Brazilian authorities at the World Food Summit in Rome 1996. This document focused on ideas regarding nutritional food security. In addition to food access, the new focus proposes that it should be of high quality, respect cultural and social diversity, and be economically and environmentally sustainable. Such a focus aims at preventing problems such as malnutrition, chronic noncommunicable diseases, excess weight and obesity.

The need to assess and organize the issue in a clear and consensual manner forced government authorities of the time to implement the various trends and ideas, interests and values and transform them into a policy for the sector.

These discussions became institutionalized through the creation of a workgroup made up of food and nutrition professionals, public policy administrators and researchers to coordinate the formulation of this policy within the Ministry of Health.

INAN had been abolished in 1997 and the area of food and nutrition was being reorganized and renewed within the Ministry of Health, since the *"workgroup designated*

for PNAN formulation was made up almost entirely of technicians and administrators from INAN."

The most active group was made up of those from INAN. They had external support from various sources, directly through the National Food and Nutrition Council, with representatives of various ministries and strong support from universities: *"so much that university professionals were almost always invited to take part during the formulation of global or sectoral programs."*

In addition to those mentioned, medical institutions, the Federal Nutritionist Council, some international organizations as UNICEF and the World Health Organization (WHO) also contributed ideas and values. These institutions were *"the most relevant for the implementation of the National Food and Nutrition Policy"*, in the view of one key informant.

This policy was established on the basis of scientific evidence indicating important issues regarding Brazil's food and nutrition profile. There were some multicentric studies, data on the assessment of the milk program (PNCC) and questions regarding the need to create the Food and Nutrition Surveillance System (SISVAN). As emphasized by one key informant *"it was a patchwork, bringing together thematic, conceptual and strategic issues that were fundamental in considering the purpose of the policy."*

There was a consensus within the PNAN formulation workgroup that it was possible to design a policy that took a broad point of view but was coordinated by the health sector. Representatives from the Ministries of Agriculture, Education, Agrarian Reform, Planning and Budget, Foreign Relations, Science and Technology and Labour and Employment were included.

Representatives of the main national health supervisors took part in the Unified Health System (SUS), the National Council of Health Secretaries (CONASS) and the National Council of Municipal Health Secretaries (CONASEMS). Policy was brought up for discussion as part of the work of the Tripartite Commission and thus the views of state and municipal supervisors were brought together.

It is important to point out the contribution to the quality of the Tripartite Commission by the National Council of Education, due to its parity-based constitution, as well as civil society and the government.

The food industries also took part as representatives of the private sector, and made essential contributions to discussions on breastfeeding and the production of breastfeeding goods.

Professionals who work with local public services, supporting and implementing food and nutrition activities throughout the country, were also called upon.

The collaborating centres in the areas of food and nutrition at the universities (Federal University of Paraná, Federal University of Goiás, Federal University of Pará, Federal University of Bahia, IMIP and National School of Public Health/FIOCRUZ) have contributed to producing empirical evidence for the design and formulation of PNAN. This provided technical and scientific support for policy makers. In addition to

the collaborating centres, Unicamp, the Federal University of Pelotas and the Federal University of Pernambuco also participated.

The workgroup also benefited from effective participation of civil society through entities such as 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 Consumer Protection Institute (IDEC), the Children's Pastoral, the Federal Nutritionists Council (CFN), the Brazilian Nutrition Association (ASBRAN) and the Association for Education in Corporate Administration. *"All of them participated in various parts of the discussion, sometimes in meetings, sometimes by circulating information through the Internet."*

Some strategic international partners such as PAHO and WHO provided physical and financial support for the workshops.

As emphasized by one key informant:

> *"We must point out the motivational and networking work performed by Dr. Denise Coutinho, who, after participating in various international forums, harmonized the international demands and the issues debated in the formulation of PNAN."*

With respect to the area of PNAN's cognitive analysis and its contributions to building a public agenda for the prevention, control and surveillance of chronic noncommunicable diseases in Brazil, the interviewees stressed that the stakeholders not only recognized infant malnutrition as an issue, but also suggested that the issue of obesity was related to improper eating habits and insisted that nutritional deficiency issues be debated. Indeed,

> *"Brazilian nutritionists and sanitarians have already been aware of this for some time, and in fact PNAN, which was approved by the Brazilian health authorities in 1999 and ratified by minister Humberto Costa in 2004, also understands it in that way."*

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

The stakeholders clearly endorsed the simultaneous struggle against chronic energy deficiencies, the most common nutritional deficiencies such as lack of vitamin A, iron-deficiency anaemia, goitre, excess weight and dietary imbalances that increase the incidence of chronic diseases such as diabetes, heart disease, and even some forms of cancer.

The stakeholders also stressed that in order to attain their objectives, many of the activities proposed by PNAN depended on the agreement and involvement of government bodies other than the Ministry of Health. Examples of activities that are typically intersectoral in nature are legislation governing nutrition labelling of foods, restrictions on advertising of unhealthy foods (and alcoholic beverages), regulations governing the maximum amount of salt permitted in industrialized foods, promoting healthy nutrition in schools and work environments, incentives for the production

of fruit and vegetables, different tax policies for healthy and unhealthy foods, urban planning measures that encourage physical activity, information campaigns using the mass media, among other things.

The problem is thus the fragility of dialogue and intersectorality of public policies in Brazil, *"especially those unable to guarantee substantive exchanges of ideas among social agents and their conceptions of wellbeing, equality principles and rules for assessing activities."*

The State is abandoning its public responsibilities, which prevents it from acquiring greater experience regarding the possibilities of joint work. The stakeholders engaged in protecting food and nutrition, as a public policy and thus a duty of the State and a right of citizens, believe that,

> *"despite these obstacles and difficulties, the movement can reclaim the value of relationships in citizens' discussions, moving from neighbourhood family and friends networks to solidarity among strangers, and shifting from mere philanthropy to the discussion of public policies."*

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

> *"The technical team in the nutrition sector was very small and managed to hear only those who were close to it, those who had already worked in the sector in the most active social movements. The policy reflects a complete lack of consultation among aboriginal peoples, the homeless, the obese and diabetics, for example. If the actual level of consultations with these groups were considered, it would be seen to be very small. It was not only due to lack of will, but also lack of resources."*

And he adds that:

> *"If we assume that it has grown in this fragmented fashion, it was not very efficient with respect to the whole situation, more concerned with the consequences than the determinants, although they were part of these determinants, even in a very unassertive way, which was possible at the time. Some sectors were lacking. At that time, ANVISA, created by Law 9782/99, was not as active as it is today. If ANVISA had existed at that time, various initiatives could have been implemented, such as food labelling."*

Among the ideas and values that influenced PNAN's formulation, an important factor was the abolition of the Food Security Council in 1994 by President Fernando Henrique Cardoso (1994-2002), when he created the Community Solidarity Program (PCS) designed to coordinate government programs and activities within civil society which *"subsequently did not deliver but ended like a philosophical play."*

In the process of formulating PNAN, there was a great deal of discussion about the human right to food from the point of view of food access, but little was said about consumers' rights.

> *"The consumer must have reliable information in order to choose his food. Considering that about 70% of Brazilian families live in urban regions, we are all consumers and far from the*

image of food consumption in a rural context. We buy food and therefore, this aspect of the policy could also have been more progressive."

With respect to ideas, one guideline became great news in more technical policy terms regarding the promotion of healthy food. Before the nutrition policy, this issue was not very clear in the area of nutrition:

"We acted very timidly in this area because there was still the understanding that the most basic issue was poverty, and that the problem was access to food. With access, everyone would exactly know what to do. This was a narrow view. We thought access would solve everything, but it does not. It is not that people do not know what to do, but they are influenced by an environment that does not encourage healthy choices. If the mother knows what is right but TV advertising promotes something else, this is a fight with unequal information. I think we made this mistake when we thought it was all a matter of access. That is not true because these environmental influences on choices have nothing to do with a person's desire to make better choices. The person may want to make better choices but they may not be available. A person may want it, but advertising does not help her make this decision."

There was intense interest and conflict regarding the idea of a specific policy on food labelling by the food industry. This happened because almost all PNAN guidelines refer to the issue of healthy nutrition. This approach does not refer only to access to food. The environment would have to be managed, which means controlling advertising, and making information accessible to consumers, as well as nutritional labelling. At that time, Brazil decided to make laws to impose food labelling, which was regulated in only two other countries, the United States and Israel. In all other countries, food labelling was voluntary. The Brazilian problem with nutrition labelling relates mainly to the industry's commercial interest in supplying end-users with the right information.

There was a need to democratize information for the end user regarding all ingredients contained in the food to be consumed, so that consumers could make their own choices. *"Therefore, the information on all food must be made more democratic. It must say how many calories it contains. Individuals have the right to choose a high-calorie food or otherwise. They want to know how many calories are contained as well as other nutrients, in order to decide whether to consume the food."*

The concern with food labelling in Brazil derives from the process of implementing PNAN, whose formulation and implementation processes took place at the same time. The opportunity arose and the technicians involved in the process introduced the ideas and tools the State needed to act in relation to the Food and Nutrition Policy.

"Labelling legislation began with a proposal. (…) The process was interesting because we made a proposal and the industry was very resistant. It was not feasible. The consumer would not understand the labels. So we said, 'OK, we'll go by servings'. We decided to use a methodology that defined amounts per serving. It was completely revolutionary. No other country had ever done anything like it. It worked and when the industry felt the Ministry was really determined to impose food labelling, their attitude toward it changed completely (…)"

With respect to Brazil's cultural diversity, the policy did not go forward in relation to the diversity of regional and local, rural and urban eating habits. The cultural issue is a mistake from the past and the present. No one could understand health in its symbolic aspect, which translates into cultural eating habits.

> *"To ignore culture is to reject some information, education and communication issues, and is another weakness in the policy."*

With respect to the prevention of chronic noncommunicable diseases within PNAN, it is interesting to note that it was more a movement of the people who were discussing it than of the sectors within the Ministry that dealt separately with these diseases. In the opinion of one key informant,

> *"we were also considering that data on increasing obesity, and the clear association between food and other diseases and hunger. We looked for other sectors, but at the time this was not their priority for health and nutrition policy."*

In the opinion of one key informant, another idea that is ignored in the PNAN and that Brazil needs to resolve is a kind of code of ethics for the relationship between the 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 we obviously have different interests in this process? Industry wants to sell or produce food with the greatest possible profit. I think there are no rules governing the relationship between the two parties and that rules are needed because we have to work together and combine our efforts."*

Not only in the areas of food and nutrition, but also in other sectors of public policy, public administrators have difficulty dealing with private initiatives since *"the tendency is to retreat and avoid a lot of dialogue because of the fear of a conflict of interests. It is even worse in a time of crisis such as the one we are going through right now. This is something that the policy does not touch on, but something that we will have to deal with soon."*

Food industries that do not begin to develop and produce healthier foods will be less profitable. This is a worldwide trend, since,

> *"those who are investing in the food sector today and not offering healthy products will lose money in the coming decades. People will demand seals of quality proving that a food is really healthy for their heart or for their stomach. People will be increasingly aware of this. As a result, there will be market competition, with some industries using this marketing to sell us their foods, claiming that they are healthier than others. When this group meets to set a policy, we all hear about it. Public control is what is going to guide the discussion so that there is consensus between the seller and the consumer, and the extent to which the consumer is informed will be the determining factor."*

On the other hand, other voices from those involved indicate that the Food and Nutrition Policy is still far from what one may wish. In fact, by the end of the 1990s, among policy makers dealing with this specific policy and even among those who discussed and managed to put this issue of food and nutrition security on the agenda, the link between

disease and diet was not obvious. They focused on hunger, lack of food, malnutrition, deficiencies, everything regarding lack of food and inadequate diet. The impact that these could have on chronic disease was unclear. Such ideas were defended by associates from university centres who participated in the whole process. *"It was included in the agenda, but not really included since other parts of the Ministry did not want to be subordinated to the area of food and nutrition because of its low status within the Ministry."*

Considering the ideas based on evidence, the stakeholders emphasized that the present PNAN might be improved with respect to the prevention of chronic noncommunicable diseases. "Obesity is becoming an enormous problem." It reappears by the end of 2004 with the Global Strategy on Diet, Physical Activity and Health (WHO, 2004) with data showing that there are 40 million overweight persons, both adults and children. One interviewee said:

> *"Much more attention should be paid to these data and to the formulation of hypertension and diabetes issues. We know that the diseases that are killing the most people are those related to heart problems, so this issue requires formulation in terms of health - not only with respect to diet, since morbidity rates are approaching those of the first world."*

Interests

Policy makers receive information from various sources: although some sources are individuals expressing their personal opinions (activists), others represent general opinions among groups of individuals. For example, interest groups represent professional associations (doctors, nurses or teachers), citizens or business sectors. Together with government agencies, the various interested parties constitute communities with the same interests with respect to specific policy areas (health, education, agriculture).

Within these communities, small groups of interested people come together to deal with specific policy issues such as promoting the publication of nutrition information on food labels, or physical activity in schools. The specific interests and how they interact may vary depending on the issue. Interest groups focused on specific issues and how they interact are called political networks or political communities.

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

Although interests and policy makers usually interact through formal channels, this may also take place informally. For example, a policy maker may be personally acquainted with a specific interest group and talk informally with that group at a social or public event about a certain issue.

Interest groups are always trying to present their perspectives on given issues to the relevant policy makers. Some of these groups are well organized and have considerable resources. Normally, this capacity allows a group to influence 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 what to do on a specific issue. Governments may also depend on these groups or individuals to help them implement policy decisions (ATKINSON, and COLEMAN, 1992).

The first conflict in the area of regulatory measures in the PNAN implementation phase was related to food labelling in Brazil. State, society and markets were at loggerheads locally and internationally regarding discussions within Mercosul and the World Trade Organization (WTO), as stressed by one key informant:

> *"We had internal resistance. We overcame that resistance, took action and managed to do something legal. It was a good proposal, but we had to harmonize with Mercosul and this was the second barrier. This showed us that having a major international issue gave us political power to go forward with a mainly regulatory agenda on the national level. Otherwise, we could not go forward. Dealing with legislation regarding food means dealing with the international food trade and with the whole international system."*

Little by little, the Brazilian technicians who had participated in the WHO sessions interacted with the international CNCD area. At the time, Brazil was going through a phase of implementing PNAN-related action regarding healthy eating, and needed international support. As part of this process, WHO technicians interested in the tobacco issue were mobilized, and this was the first opportunity (KINGDON, 1995) to obtain international support. This was the first movement regarding the guidelines to promote healthy eating and physical activities as a strategy for combating CNCD in Brazil.

This mobilization for approval of healthy nutrition as a component of CNCD prevention, control and surveillance began with the activities regarding the harmful effects of smoking on the quality of life. Thus, the legislation on the production and consumption of tobacco, with its regulatory component, was the beginning of the international mobilization.

WHO's technical sector, after placing the tobacco issue on the international agenda, began an internal mobilization to institutionally regulate the issues of healthy diet and physical activity . Within this context, Brazil received crucial support from WHO in defining this strategy, considering that,

> *"we need an update of the scientific basis, since without a sound scientific base, we cannot convince anyone. Second, we need an international instrument agreed upon between countries that defines the area of activity and gives us political backing. We can do it in Brazil but we will need greater international political support."*

After Brazil was mobilized, other countries managed to include this issue on their local agendas. The Ministry of Health, through the chronic diseases sector, organized a meeting in 2002 with the WHO representative, who were very interested in what was taking place in Brazil.

This international meeting aimed at mobilizing WHO's institutional interest. *"We brought the various experiences of states and municipalities to show WHO representatives what we were doing in Brazil."*

Thus, an opportunity arose: *"It was a very successful meeting that brought forward a series of ideas confirming the importance of this movement."* Therefore, Brazil played a central role in the Global Strategy formulation process. "Brazil was not the only country to participate, but our participation was very important, beginning with my initiative and later on with their visit. That was when they decided that it was important to organize a Global Strategy to promote healthy eating."

At a WHO meeting in 2002, Brazil and a number of other countries got together and made an effort to argue and persuade, based on empirical evidence and on the acquisition of institutional space for ideas and interests. Other countries then approved a resolution calling on WHO to develop a Global Strategy. As a result of this process, an international reference group was formed with the participation of the scientific community and the programming area. Brazil was represented in the international workgroup by a public health technician who was also an academic. But *"they invited me to focus on a public health perspective from the program point of view, less scientific and more pragmatic,"* says one interviewee.

Other international agencies such as FAO and UNICEF participated in the group. This group was appointed to work together with WHO with a view to formulating regulations for the Global Strategy for Healthy Eating and Physical Activities, beginning in 2002, as one key informant explained: *"we worked for about two years, in terms of process, similar to the PNAN policy formulation process in Brazil."*

The process of developing the Global Strategy began with the preparation of a technical document, based on the PNAN model, as a first draft. This document was discussed regionally, in the territories established by WHO. Each region discussed the document from the perspective of specific demands. At the same time, WHO was holding discussions with non-governmental organizations in order to understand the consumers' perspective. The discussions also involved the private sector. The process of formulating the WHO Global Strategy culminated in a final text approved in 2004.

Thus, it is clear that the PNAN formulation and implementation process from 1999 to 2004, especially with its healthy eating guidelines, contributed to the formulation of a Global Strategy in 2004. On the one hand, as a national public policy, PNAN was strengthened by the Global Strategy. On the other, the Global Strategy was also framed and strengthened on the basis of the experience of member countries, as this interviewee explained:

> *"On the other hand, the Global Strategy is based on the experiences of the countries. It is a two-way process. We needed international support. Now that I am on this side, looking at reality, experience, the practice of countries, for example, one thing that I asked the Ministry for was recently launched, the 'New Brazilian Diet Guide'. The slogan created by the Ministry was 'Feed your Health'. I think it is wonderful. It is a simple idea, but says everything. This is a product of something shared with the states, discussed with them, voted on, and, even better, a concept that was worked on together, and so has greater backing. It has already been translated into all languages with a caption thanking Brazil for having offered this slogan, etc."*

Institutions

When discussing public policies, we consider not only the perspective of the State carrying out the action (designating the process by which the programs and activities are established and put into practice and manifested as political-administrative devices coordinated in principle around explicit objectives (MULLER and SUREL, 1998), but also the actions or omissions of the State in relation to the demands of society (O´DONNEL, 1982, 1986).

The institutions, at the policy formulation phase, are the formal structures and processes through which policy makers decide on public policy issues. These formal structures include the political executive; the legislative, bureaucratic and judiciary branches of government; the formal rules created by legislation; regulations and legal decisions; and formal governmental structures and processes, including ministries and agencies (ROTHSTEIN, 1998).

How the government is organized may have a significant influence on its ability to react to public health issues. For example, the traditional organization of ministries of Health in many countries leads them to concentrate only in complying with the legislative requirement of financing hospital services and doctors. This focus may cause delays in the recognition of other options for promoting health and preventing disease and in the use of public resources to keep the population healthy.

The reality of divergent organizational mandates and the lack of experience in overcoming sectoral limits to create harmonized policies are recognized obstacles to the factors determining how policy formulation is approached (LAVIS, *et al.* 2001).

Although various alternative ways of evaluating the health sector have been suggested in the literature (MCKAY, 2001), the existing predisposition created by present legislation and the corresponding structures and processes may have created a greater tendency against considering new policy ideas. Non-traditional organizational approaches may be a critical factor in the government's ability to respond effectively to present and future public health issues (DESVEAUX et al., 1994).

The PNAN elaboration process, as already analysed, began within the Ministry of Health, a place where the political guidelines were formed, debated and negotiated among government policy administrators, stakeholders from civil society, and the market.

As a starting point for the negotiations, consensus-building and discussions, a group of specialists in the field of food and nutrition, former workers of the National Food and Nutrition Institute, were asked to prepare a basic document containing scientific evidence to support the discussions and the necessary arguments to formulate public policies. As Majone says, "public policy is made up of words. In written or oral form, discussions are basic at all stages in the policy formulation process" (MAJONE, 1997, p. 35). Based on this first document, which would have a persuasive power based on empirical evidence regarding food and nutrition problems, the technicians responsible for the area held three lengthy meetings with representatives from government institutions and civil society.

"I believe there is no doubt that this was the first major experience that was not vertically imposed from above. It was debated and agreed to with contributions from several institutions."

Again according to Majone, in any organization, public or private, discussion is an ongoing process. He argues that the discussion process, aimed at convincing others, underlies the entire political system. Within organizations, this process is so obvious that it is at the base of both politics and democracy, and democracy is a government system based on discussion. Stakeholders from both government and society interested in a political issue, such as political parties, the legislature, the executive, the courts, the media, interest groups and independent specialists are participants in a continuous process of debate and mutual persuasion (MAJONE, 1997, p. 35).

We could then ask: How did this process to persuade and influence technical specialists, based on a basic document about the need to establish a specific policy in the field of food and nutrition, originally arise?

As mentioned in the item on the historical process to form and constitute a public agenda on food and nutrition in Brazil, most of the stakeholders interviewed argued that, after the abolition of INAN, the area of nutrition was too fragmented within the Ministry of Health, as were other related areas, and responsibilities scattered among various programs. For example: the child nutrition sector took over some programs and the National Health Foundation took over others.

The process of abolishing INAN and the subsequent fragmentation of activities falling under the Ministry of Health caused dissatisfaction among the nutritionist community, not only among those assigned to INAN and reassigned to technical sectors of the Ministry of Health, but also nutritionists who worked in other states of the country. The decision caused indignation within the national scientific community, with echoes in international organizations in this field.

At the institutional level, the area of food and nutrition had three features indispensable for policy formulation: a) a national issue manifested by the epidemiological relevance of the issue and included on the public agenda in response to demands raised by society in the area of public health; b) a favourable opportunity within the Ministry of Health to reorganize the area of food and nutrition (human resources, technicians, budget); and c) political pressure from State and civil society stakeholders interested in redefining State action with regard to food and nutrition.

PNAN was the second policy regulated within the Ministry of Health under Legal Directive No. 710 of June 10, 1999. It represented a political, administrative, institutional and sectoral decision by the Ministry with respect to food and nutrition problems, as well as institutional problems caused by the hollowing out of INAN before it was completely abolished.

In fact, there were three parallel processes to be followed through on: first, to reorganize the food sector at the administrative, technical and political levels; second, to define food and nutrition policy for the entire country and; third, to continue government activity still under way, even after the abolition of INAN, as confirmed by this interviewee:

> *"In the process of formulating PNAN policy, we could not wait for its regulations to begin reorganizing programs. On the other hand, we could not reorganize programs at the Ministry of Health without a political basis with sound support for moving forward. (…) From the administrative point of view, we again began to assemble in the Health Policies Secretariat the various scattered nutritional intervention activities."*

From the political and institutional point of view, as argued by technical personnel, the fragmented activities concerned child nutrition, beginning with breastfeeding and complementary nutrition, programs to combat malnutrition or nutritional deficiencies, as well as programs in the micronutrients area, the program to reduce use of salt, and the program to distribute vitamin A. There were also initiatives to combat anaemia.

This time of crisis during the phase of reorganizing food and nutrition activities in the institutional domain favoured dialogue between those responsible for formulating and implementing policies. As a starting point, discussions began on the need to promote an adequate diet and to structure action, already with the aim of preventing chronic disease. In fact, under these circumstances, the food and nutrition sector began talks with the chronic disease sector on action related to diet for diabetics and hypertensive people, but still in embryonic form.

In 1998, some action had already been implemented and the process of formulating PNAN began. In other words, the policy formulation and implementation processes occurred simultaneously.

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

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

After the basic document was prepared, it had to be submitted for appraisal by State and society stakeholders and the market interested in the area. As one key informant argues, the institutional process of formulating and approving PNAN,

> *"was made as inclusive as possible, since this was the objective of the policy formulation process. Therefore, the management of the administrative area, that is, the reorganization of programs in parallel with the plan to reformulate the policy was interesting, because the very process of formulating a policy was mirrored in the way we were rethinking the programs, and redesigning, improving or even maintaining them."*

This basic document was also presented in a discussion forum organized by PAHO. In this forum, the main stakeholders in the area of nutrition were identified, especially those associated with the Executive Power.

After the identification of stakeholders interested in the area, the commission formed to shape this policy invited other ministries and stakeholders from the legislature and civil society, including organized movements, the food private sector and the scientific and international communities.

With respect to the stakeholders from civil society, the interviewees stressed the importance of the consultation work done at the National Forum on Food and Nutrition Security (FBSAN), which brought together a wide representation of society, with people from Citizens' Action against Hunger and Poverty (1992-1994).

FBSAN was created in 1998. Among the main goals and actions implemented during its lifetime were (FBSAN, 2003):

a) Mobilizing society around the issue of Food and Nutrition Security and cooperating in the formation of favourable public opinion on this subject;

b) Promoting the development of proposals for national and international policies and action on Food and Nutrition Security and the Human Right to Food. Placing this issue on national, state, and municipal policy agendas and cooperating in international debate on the subject;

c) Placing this issue of Food and Nutrition Security on government agendas at various levels;

d) Encouraging the development of local or municipal action to promote Food and Nutrition Security;

e) Cooperating in training stakeholders from civil society with a view to improving the effective participation by society at the various social management levels; and

f) Reporting and monitoring governmental responses regarding violations of the right to food.

The National Forum on Food and Nutrition Security was made up of some 120 non-governmental organizations interested in tackling the problems of hunger and poverty, and food and nutrition insecurity in Brazil. This forum made a significant contribution, not only with respect to content, but also through the inclusion of other organizations that were especially invited, such as the Brazilian Nutrition Association on (ASBRAN) and movements organized by nutritionists. In addition to participating in the forum, these also played a specific role, not only through the forum but also by representing entities interested in formulating policy.

As emphasized by one interviewee,

> *"it was a mixture of participation through representatives and direct participation. We estimate that there were about 120 organized groups in total that took part in the debates. The private sector was also present and its participation was considered vital to the debate from the beginning so that it could assume responsible for the entire agenda."*

At that time, the nutritionists movement was relevant to the political scene. At a congress on nutrition in Brasilia, through the press, they called society's attention to the importance of the human right to food. The recognition of food as a right thus helped incorporate this discussion within the draft policy.

The work meeting held by PAHO in 1998, as the first opportunity to share a purely technical document in a forum of a primarily political nature, was the occasion for government administrators to recognize that PNAN's approach, philosophy, and central theme should be food as a human right.

Thus, at the same time that this represented progress in the area of concepts, ideas and values, government administrators were still not clear on how to proceed to incorporate this new terminology of food and nutrition as a human right into the government agenda. As stressed by one 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 programmatic terms? We had little idea."*

Thus, the technicians had to request support from the human rights section at the Ministry of Justice. A small drafting group was formed to reread the basic text of the policy from the point of view of the human right to food with the support of human right specialists.

In the institutional sphere, at the same time as the basic text was being reviewed, with contributions from the various stakeholders interested, Ministry of Health technicians, already organized under the General Food and Nutrition Policy Coordinator (CGPAN), wanted to test the programmatic implications of that discourse still being worked out (the human right to food) based on the following questions: What does this new discourse mean? Is it just another form of rhetoric or does it have programmatic substance? In the opinion of one interviewee, this was a period of discussions that led to many arguments and debates during the policy formulation process. These arguments also created an opportunity to test this discourse from a pragmatic-programmatic point of view in the activities relating to anaemia.

The technical sector decided to chose anaemia as the first example to implement in programmatic terms the concept of a human right, in other words, the methodological discussion regarding what was to be done to ensure that programs to combat anaemia contribute to efforts to give concrete shape to the human right to food, and on how the anaemia problem could be dealt with within this context, within this legal framework., Every administrator must thus be reminded of his responsibilities.

This right has implications for the duties of various stakeholders, and they must agree on deadlines and how indicators are to be formulated, and make decisions on how to publicize the information and mobilize society, allot human and material resources, and formulate a results protocol, among other aspects referring to the processes of formulating, implementing and assessing public policies. The agreement was duly signed by the partners in an official document.

At the level of institutions and action instruments, the change in the concept also required broad discussions on the programmatic implications of the concept of the

human right to food as a PNAN value. A basic question regarding the understanding of the interested parties referred to the relationship between State institutions with the "beneficiaries" of public services. As one interviewee sees it, the relationship between State, society and the market would have to change. The subject of the activity must not be only a target of public policies, but also a participant: *"Citizens must know that food is a right for them and for their families. It is not simply a benefit."* This change in how the subject of the professional activity is regarded also implies empowering human resources for the delivery of health services so that they are aware they are respecting a right.

Thus, on the institutional level, with the approval of PNAN, a permanent process of empowering human resources involved in the planning, monitoring and assessment activities was launched in decentralized fashion, as the Federal Constitution and the Unified Health System (SUS) proclaims. *"We empowered all the states [of the Federation] in an interesting process, and then the States made their own empowerment plans for the municipalities and trained them."*

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

Beginning with the learning process, the team began developing a series of public opinion surveys that culminated in changes to the main program: milk distribution, with an assistencialist focus. More inclusive programs were contemplated, which culminated in PNAN directives. The process of formulating PNAN, in the opinion of one interviewee, was inclusive, participatory and sound. This policy still remains the official policy of the Ministry of Health, *because a policy must have a longer life*.

The arguments regarding the directive relating to the human right to food progressed to the extent that discussions on the directive on the intersectorality of the food and nutrition policy with other sectoral policies (education, agriculture, employment, social development, among others) required an immediate reorganization of the area with some sectoral portfolios involved in the formulation process.

According to one interviewee, a remarkable example refers to the lack of definition, from the workgroup in charge of policy conception and formulation, with respect to the following dilemma: would the food security policy incorporate the whole dimension of food security, from the production to the biological use of food, or would it be a mere part of the health area, a sectoral policy inserted into a broader policy on food security?

One key informant reminds us that the second definition, a sector of the health sector, was decided on for two reasons: First, because the technicians at the Ministry of Health that year called for the formulation of a food and nutrition policy to constitute a national health policy. Second, because the technicians considered that the health agenda with respect to food security was still fragile and incomplete.

"We had to define this agenda (...) do our part well, contribute to food security (...) PNAN was, in fact, formulated as a health policy and was endorsed by the Ministry of Health. From the beginning, it had been decided that was how it would be. That is, at the discussion phase at the National Health Council, we noticed that the health area did not take nutrition into account. But if health does not take nutrition into account, how can we deal with intersectorality and with the policies of the other sectors. The debate was reopened at all levels. So we contributed to the intersectoral debate but we will not assume responsibility for the whole spectrum of activities necessary for food security."

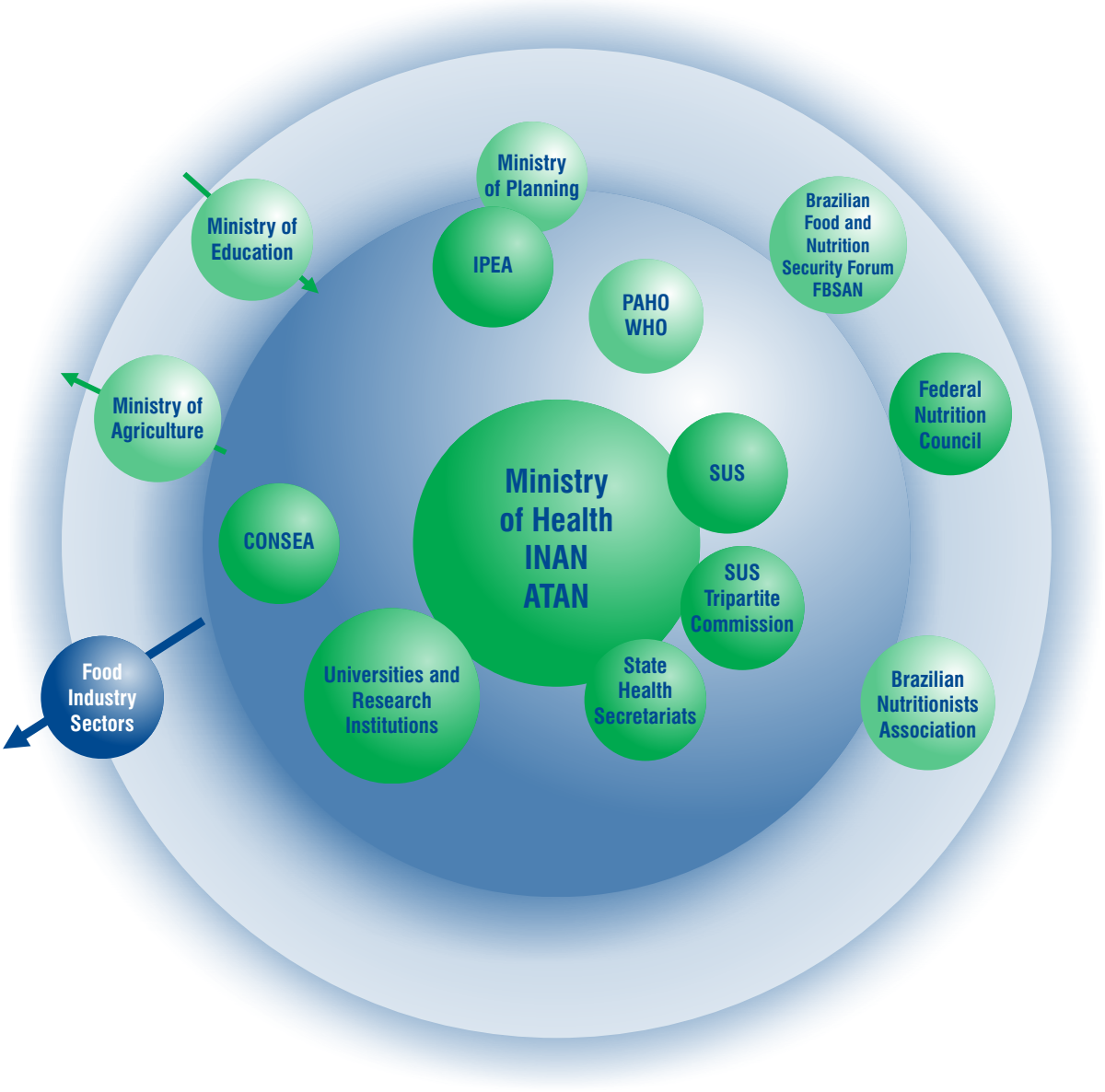
At the stage of deliberation regarding the policy concept, the National Health Council was a principal stakeholder. One interviewee argues that when the policy text went to this Council, the need to argue for the idea of intersectorality on one hand, and the magnitude and complexity of the food security concept on the other, became the main issues in the debate. After this debate and with strong arguments from specialists and activists, the first PNAN directive was born: the need for intersectoral activity to ensure that people can eat. It was a public policy, as a duty of the State and a right of the citizen, which culminated in the complete PNAN text, governed by Legal Directive No. 710, of June 13, 1999.

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

According to the analysis diagram of the process of formulating PNAN on page 14, public policy instruments refer to laws, costs, programs and services that give concrete form to state action within a given field of intervention.

The process of formulating PNAN revealed the formation of a set of policies formed by groups and networks with converging and diverging interests regarding the drafting of PNAN directives. Themes were analysed with respect to context, institutions and ideas in association with the main bodies interested in food and nutrition issues in Brazil from 1990 to 1999, as shown in the following diagram:

Policy Community: PNAN Formulation (1990-1999)



After the PNAN was approved in 1999, various government and society stakeholders became interested in public policy instruments governing the area of food and nutrition, including plans, programs and services. On the next page, we show the most important activities by sectoral policy area in the Brazilian government during the period from 1999 to 2005.

Policy Community: PNAN Implementation (1999-2005)

Programs Related to PNAN and SAN (1999-2005)

Ministry of Health

In March 1998, the Ministry of Health established the Incentive to Combat Nutritional Deficiencies (ICCN) by means of Ministry Legal Directive No. 2409, of March 23, 1998 (BRAZIL, Public Prosecution Service MS/SAS/CGPAN, 1998).

This was a program of financial incentives for the development of activities to combat malnutrition, transferred to Brazilian municipalities directly from the National Health Fund to the Municipal Health Funds - and was an essential part of the Primary Care Floor (PAB).

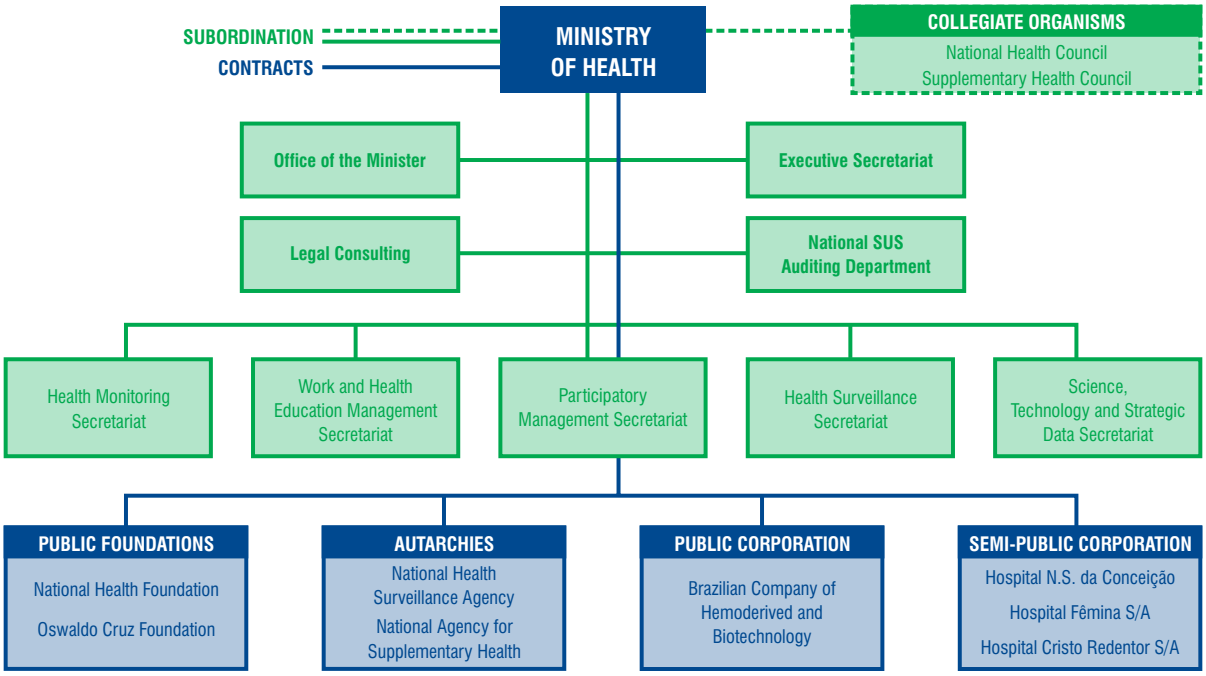
Based on the Legal Directive that created the Program, children between 6 and 23 months of age were considered priority groups for receiving this financial incentive. Other groups considered were pregnant women, the elderly and children between 24 and 59 months of age. Beneficiaries received 3.6 kg of whole milk powder (or 30 litres of sterilized liquid milk) and one litre of soy oil each month for each child between 6 and 23 months of age. Thus, for each child within this age group, an amount equivalent to R$180.00 (reals) per year was provided in milk and soy oil. Additional resources corresponding to 50% of the amount transferred for the nutritional care of children between 6 and 23 months were also invested in each municipality to serve other population groups (pregnant women, nursing mothers, children over 24 months, the elderly, etc.) or to establish other appropriate food and nutrition promotion activities.

In 1998, the year it was established, ICCN covered 3225 municipalities, reaching 597,725 beneficiaries. In 1999, this was increased to 4793 municipalities, reaching a total of 850,013 beneficiaries. In 2000, it reached 871,098 beneficiaries in 5026 municipalities. By December 2001, 5127 municipalities had qualified and approximately 880,000 children, pregnant women and elderly people were being served. By the end of 2001, ICCN reached 92% of Brazilian municipalities, serving 95% of the total number of expected beneficiaries (922,536 beneficiaries). When ICCN was established in 1998, the annual financial ceiling was R$167 million (reals). During the period from 1998 to 2002, about R$574.60 million (reals) were transferred as incentives to fight nutritional deficiencies (BRAZIL/MS/CGPAN, 1998).

According to the report on ICCN prepared by CGPAN, during its existence, the following results were observed: a) increased percentage of children receiving up-to-date vaccinations; b) increased percentage of children and pregnant women receiving up-to-date weight assessment; c) increased percentage of pregnant women receiving up-to-date tetanus vaccinations; d) increased number of prenatal visits to the doctor among beneficiaries who are pregnant; e) increased percentage of parents taking part in educational activities; f) increased percentage of nursing mothers able to respond correctly regarding breastfeeding and healthy feeding practices; and g) increased quality of information provided by mothers.

In 2001, by means of Provisional Measure No. 2206 of August 2001, the National Program on Minimum Income, with links to the Food Allowance Program (PBA), was created. According to the report prepared by CGPAN (2003), a large number of Brazilian municipalities had joined by December 2002, which made continuation of both programs (PBA and ICCN) impractical. Therefore, in October 2002, an administrative decision was made through the publication of Legal Directive GM/MS 1920, providing that "as of January 1, 2003, the money transfers referred to in Legal Directive GM-MS 709 of June 10, 1999 targeting the Incentive to Combat Nutritional Deficiencies – ICCN - would be terminated."

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



Through its organizational structure, the food and nutrition area is linked to the Health Care Secretariat, which has the following areas of responsibility (Art. 13, decree No. 5678, of January 18, 2006).

I– Taking part in the formulation and implementation of health care policy, observing SUS principles and guidelines;

II– Defining and coordinating the integrated health action and services network systems;

III– Establishing standards, criteria, parameters and methods to control the quality and assessment of health services;

IV– Supervising and coordinating assessment activities;

V– Identifying reference services to establish technical patterns for health care;

VI– Formulating and proposing standards to regulate relations between SUS management levels and private services hired to provide health care;

VII– Coordinating, supporting and assessing the activities of Ministry of Health service units on a nationwide scale;

VIII– Providing technical cooperation to improve the administrative and operational capability of States, municipalities and the Federal District;

IX– Coordinating the formulation and implementation of SUS assistance regulation policy;

X– Promoting the development of strategic activities aimed at reorganizing the health services model, taking as structural theme primary health care service activities; and

XI– Participating in the formulation, establishment and implementation of standards, instruments and methods to strengthen SUS administrative capability at all three government levels.

At present, the SAS structure includes five departments and one institute, namely:

1. Department of Specialized Services;

2. Department of Regulation, Assessment and Systems Control;

3. Department of Primary Care;

4. Department of Strategic Programmatic Activities;

5. National Cancer Institute; and

6. Department of Hospital Management of Rio de Janeiro State.

Food and nutrition content is the responsibility of the General Food and Nutrition Policy Coordinator (CGPAN), which reports, within the Ministry of Health, to the Department of Primary Care in the Health Care Secretariat.

Its mission is to program activities in accordance with National Food and Nutrition Policy (PNAN) guidelines. Some of its responsibilities are the following:

I– Planning, guiding, coordinating, supervising and assessing the process of implementing the National Food and Nutrition Policy, with the goal of improving the nutritional conditions of the public throughout their lives and complying with the principles and guidelines of the Unified Health System (SUS);

II– Proposing, planning, standardizing, managing, monitoring and assessing, at the national level, the implementation of plans, programs, projects, action and activities needed to put into effect the National Food and Nutrition Policy;

III– Working with States, Municipalities and the Federal District to boost their commitment to programs and projects in the area of Food and Nutrition and providing technical cooperation to improve management and operational capability in the area;

IV– Promoting relationships with national and international development, finance and research departments, entities and agencies for the development of cooperative projects, studies and research on food and nutrition;

V– Promoting and encouraging continuing education for human resources involved in implementing all PNAN programs and projects; and

VI– Organizing and taking part in intersectoral activities for the planning and implementation of sustainable food and nutrition activities, programs, plans and policies.

Thus, CGPAN plans activities in the field of food and nutrition in accordance with PNAN guidelines and activity at state and municipal levels, highlighting the Promotion of Healthy Nutrition (PAS), which aims at supporting Brazilian states and municipalities in developing activities and approaches that contribute to health promotion and disease prevention.

According to the government administrator responsible at the Ministry of Planning level for managing the general assessment of the Healthy Diet Program, (BRAZIL, MINISTRY OF PLANNING, 2002):

> *"By January, 2000, the Incentive to Combat Nutritional Deficiencies (ICCN) had already been implemented in 87% of Brazil's 5507 municipalities, with an estimated 850 thousand beneficiaries (92% of expected maximum coverage). ICCN resources transferred more than R$ 127 million to the municipalities in 1999. In 2000, more than R$ 152 million was invested in fighting nutritional deficiencies. That year, the Healthy Diet Program was structured in four main activities with resources planned by the 2000–2003 MYP. During the period from 2000 to 2002, there was no problem of continuity in the financial flow that could hinder the implementation of the Healthy Diet Program. The funds allotted to the Healthy Diet Program suffered no interruption in the year 2002. There were no continuity problems in the financial flow that could hinder the implementation of the Healthy Diet Program. Even so, goal fulfillment was below forecasts. Both material and infrastructure resources and human resources are adequate for implementation of the Program. There were no changes in the budget law in 2002 that could affect the Healthy Diet Program."*

Food and Nutrition Surveillance System (SISVAN)

The Food and Nutrition Surveillance System (SISVAN) was announced in the 1970s during the World Diet Conference (Rome, 1974) and was recommended by WHO, PAHO, FAO and UNICEF, with the aim of: *"(...) monitoring the conditions of less favoured groups among the population at risk, and providing a quick and ongoing method for assessing all factors influencing food consumption patterns and nutritional situations"* (FAO/WHO, 1974).

Implementation of SISVAN began in Brazil in 1977, when the organization of an information system to monitor the food and nutrition situation of the Brazilian population was proposed. Its regulations came later, in 1990, with Ministry of Health Legal Directive No. 080 (Oct. 16, 1990) and were considered a prerequisite for the transfer of federal funds for activities to combat malnutrition. Today, Ministry of Health Legal Directive No. 2246, of October 18, 2004, sets out basic guidelines for the implementation of Food and Nutrition Surveillance as part of the SUS's basic health activities throughout Brazil. The three focus areas initially proposed by SISVAN in Brazil were:

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

The purpose of these theme areas was to provide information for planning activities to prevent and control nutritional problems among the public.

SISVAN was mainly designed to collect information to support public policies to improve nutrition conditions among the public, to maintain an up-to-date diagnosis of Brazil's nutrition situation with respect to relevant public health problems in the field of food and nutrition, and to identify geographic areas and population groups at risk, assessing time trends in the problems detected and collecting data to identify and weigh the most relevant causal factors behind these problems.

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

> *"Nowadays, SISVAN's strategic and doctrinal principles have become particularly timely, pertinent and relevant. Since it was formalized in 2003, food and nutrition security has been recognized as the greatest priority of Brazil's government and society. In the field of health, this role has become particularly important in the light of the dynamic food and nutrition transition process the country is going through. Problems have become highly diverse, generalizing a variety of demands from all ages and all socioeconomic strata." (BATISTA, 2004)*

The National Food and Nutrition Policy (PNAN) provides SISVAN with the monitoring of the nutritional and food situation it needs to increase flexibility in its procedures and expand its coverage throughout the Country. The system was consolidated with particular support from the Food and Nutrition Collaborative Centres scattered around the country and the Food and Nutrition State Technical Sectors existing in every Brazilian state and in hundreds of municipalities throughout the country.

SISVAN's role includes continuously describing and predicting trends in food and nutrition conditions among the population, as well as the factors that determine them. In its monitoring of food and nutrition, the System must focus on pregnant women and the growth and development of children, which are the focus of all work carried out in the service network, especially with respect to primary health care, and bearing in mind its commitment to universality. With respect to the service network, SISVAN must incorporate within its service routines the monitoring of the nutritional situation of each user, with the aim of detecting risk situations and the limitation of activities that may reduce its effects and the likelihood of making the situation return to normal. Another priority is the mapping of deficiency endemics in a way that will reveal their distribution in space and indicate the magnitude of protein-energy malnutrition, anaemia, and Vitamin A and iodine deficiency, in addition to the monitoring of chronic noncommunicable diseases related to nutrition and lifestyles considered inadequate.

SISVAN's mission is thus to prepare a basic list of indicators capable of identifying events of greatest interest, such as: food availability, qualitative and quantitative aspects of the diet consumed, breastfeeding practices and characteristics of the complementary post-weaning diet, birth weight distribution, prevalence of protein-energy malnutrition, anaemia, obesity, iodine and vitamin A deficiencies and other micronutrient deficiencies related to chronic noncommunicable diseases.

Brazilian Health Surveillance Agency

Since the 1980s, the increasing participation by the public and bodies representative of various segments of society within the political process has influenced the current concept of health surveillance. According to the constitution, this includes activities designed to allow the Government to play the role of guardian of consumer rights and provider of the conditions for a healthy population (EDUARDO and MIRANDA, 1998).

Thus, the creation of a Brazilian Health Surveillance Agency (ANVISA), in 1999, by Law No. 9782/99, became a government priority. The responsibilities of Health Surveillance are described among the powers of the Unified Health System (SUS), art. 200 of the Federal Constitution, i.e., "to carry out activities of sanitary and epidemiologic vigilance as well as those relating to the health of workers." Carrying out such health surveillance is included among the SUS's fields of activity – Clause I, paragraph "a" of Art. 6, and is part of the National Health Surveillance System defined by the law that created the Brazilian Health Surveillance Agency.

Brazil has a sophisticated National Health Surveillance System (SNVS). The system is made up of the Ministry of Health, the Brazilian Health Surveillance Agency (ANVISA), the National Council of Health Secretariats (CONASS), the National Council of Municipal Health Secretariats (CONASEMS), State, Municipal and Federal District Health Surveillance Centres (VISAS), Central Public Health Laboratories (LACENS), National Health Quality Control Institute (INCQS), Oswaldo Cruz Foundation (FIOCRUZ) and State, Municipal and Federal District Health Councils with respect to health surveillance activities.

The health surveillance activities directly related to nutrition are two: ***a) food labelling***; and ***b) food security***.

a) Food Labelling

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

A number of activities were undertaken to promote healthy nutrition for the people of Brazil. At the same time as they facilitate control of chronic noncommunicable diseases and their risk factors, these activities also contribute to improving the nutritional situation of the elderly. Nutrition information must appear on all food packages, allowing wide disclosure of a number of informational and educational measures.

Beginning with this effort, the Ministry of Health has published various regulatory instruments.

In addition to the legal directives mentioned above, the following resolutions were also issued by ANVISA to take into consideration the goals set out by PNAN:

- RDC Resolution No. 28, March, 28, 2000. Approves the Technical Regulations Governing the Basic Procedures for Good Manufacturing Practices and Health Inspection Guidelines for Salt Processing Companies.

- RDC Resolution No. 53, June, 15, 2000 (DOU [Official Gazette of the Union] June, 19, 2000). Sets Out Technical Regulations Governing the Determination of Identity and Quality for Cereal Bran-Based Mixtures.
- RDC Resolution No. 91, October, 18, 2000 (DOU of October 20, 2000). Approves the Technical Regulations Governing the Determination of Identity and Quality of Soy Based Foods.
- Resolution No. 39, March, 21, 2001. Approves the Table of Reference Values Governing Packaged Food and Drink Portions for Nutritional Labelling Purposes.
- Resolution No. 40, March, 21, 2001. Approves the Technical Regulations Governing Mandatory Nutritional Labelling of Packaged Food and Drinks, Standardizing the Statement of Nutrients.

b) Food Safety

The safety of food offered for consumption by the public is one of Public Health's challenges. The National Health Surveillance System, coordinated by ANVISA, in its food control activities, prioritizes the Modern Health Inspection Systems Human Resources Development Program established in July 2001 in partnership with the Pan-American Health Organization (PAHO).

Training courses are divided into four levels: a) Good Manufacturing Practice (GMP); b) Sanitation Standard Operating Procedures (SSOP); c) Hazard Analysis Critical Control Points (HACCP); and d) Auditing and Methodology.

Knowledge of new inspection methods and tools and the educational process passed on through technical workers from state health surveillance services increased greatly among technical workers at municipal surveillance centres. This made it possible to increase coverage and speed up action aimed at: a) assessing practices adopted by manufacturers and service providers in the food industry; and b) intervening in situations of risk from chemical, physical or biological hazard contamination, or in case of risk of possible injury from food offered for consumption (BRAZIL, MS/ANVISA, 2006).

Ministry of Education

School Grants Program

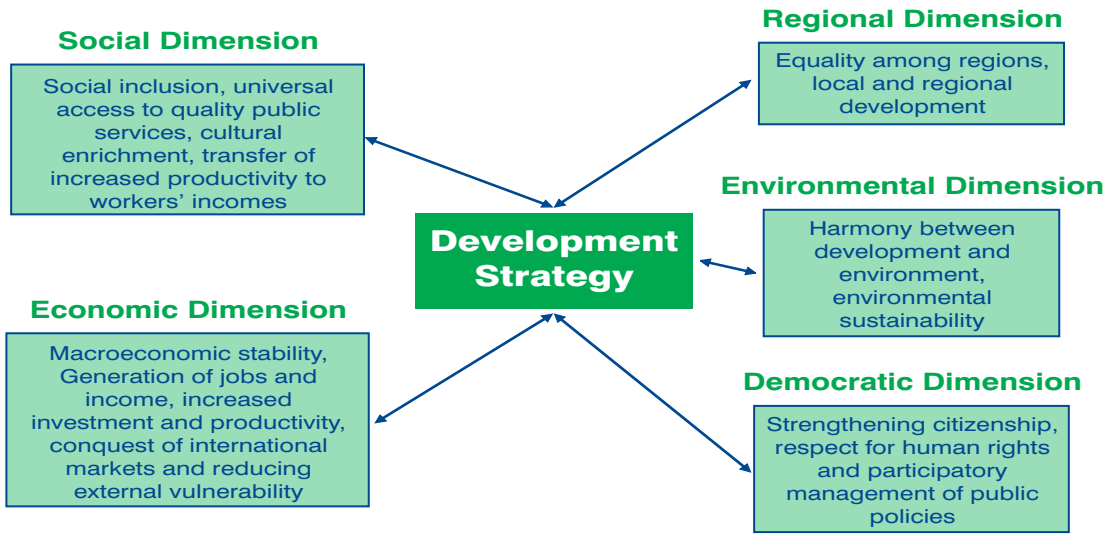
Law No. 10,219, of April 11, 2001 created the Minimum Income Program linked to education – "School Grants" – with a proposal to grant monthly monetary benefits to thousands of Brazilian families in exchange for keeping their children in school.

According to the 2002 assessment report of the School Grant Program (BRAZIL, 2002), by the end of 2001, the program had reached 5470 municipalities, i.e. 98% of Brazil's 5561 municipalities, representing more than 8.2 million children from 4.8 million low income families. During that year, families received R$409.9 million in benefits. In 2002, the activity was expanded, and only 15 municipalities remained unreached, out of a total of 5561 municipalities in Brazil, and coverage grew to some 5.1 million families, benefiting approximately 8.7 million students.

Intersectoral Programs in the Context of PNAN and Food and Nutritional Security (SAN) (2003-2005)

In 2000, discussions about food security gained new momentum when the NGO "Instituto da Cidadania" (Citizenship Institute), directed by Mr. Luís Inácio Lula da Silva, brought together 100 experts to take up food security issues and design a political project to fight hunger and poverty in Brazil as one of the strategies of the Multi-Year Development Plan (2004-2007), with five dimensions, as can be seen in the diagram below:

Five Dimensions of the Strategy



Source: *Pagnussat, Brasília, ENAP, 2003*

In order to fulfil its social dimension, the 2004-2007 MYP chose as its priorities combating hunger and poverty, income concentration, illiteracy, slave labour, child labour, as well as regional inequalities in the country, among other social goals.

One of the first decisions of the Lula government was to re-establish CONSEA on January 30, 2003. This Council is consultative in nature and advises the President with respect to National Food and Nutrition Policy (PNAN) guidelines. Decree No. 5079, of May 11, 2004, sets out its composition, structure, jurisdiction and function.

The Council resumed its former implementation experiment begun in 1993 and interrupted in 1995. It thus revived and defined the issue of Food and Nutrition Security (SAN), providing it with a distinct political status, transforming it into a strategic government policy, (BRAZIL, MS/CGPAN, 2005, p. 54) and making the Zero Hunger Program (FUCHS and PASSOS, 2006) the principal strategy for intersectoral organization to attain all five dimensions of (2004-2007) MYP development.

Beginning with the revival of CONSEA's work, at the federal level, a network of Regional CONSEA meetings began to be formed, scattered through Brazil's five regions (the North, Northeast, Southeast, Centre-West and South), (PROJETO [FAO] UTF/BRA/064/BRA - Terms of Reference 19204). The mission of this project was to *"Carry out strategic activities to facilitate the implementation and attainment of the anticipated results by the Zero Hunger*

Program, in terms of the social and economic policy of the Brazilian Federal Government." It had three main goals: a) to support implementation and management of the national food and nutrition security policy; to reduce vulnerability to food insecurity in rural, urban and near-urban areas; and c) to introduce an assessment system for the Zero Hunger Program.

The inputs for the development of work by the regional CONSEAs are the reports from their regional meetings for CONSEAs in the North, Northeast, Middle-West, Southeast and South Brazilian regions; meetings with officials from the Food and Nutrition Security Secretariat of the Ministry of Social Development and Hunger Eradication (MDS); and meetings with directors of the National Council for Food Security and Nutrition (CONSEA), with participation in meetings of CONSEA's Technical and Theme Groups at the national level, among other employment and social mobilization strategies used to deal with the issue.

During the development of work with the network of regional CONSEAs, eight priority areas for food and nutrition security were identified:

a) Human Right to Food: defence of the inclusion of the Human Right to Food in state constitutions and municipal laws; recognition of the 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 a reference during drafting of the Organic Law on Food and Nutrition Security;

b) Official establishment of CONSEAs: establishment of their own budget and guarantee of financial, material and human resources for operation of State Council Secretariats; drafting and approval of the Organic Law on Food and Nutrition Security; increasing discussion on public policies, not limited to food security; holding Thematic Meetings for specific groups, in particular, indigenous and Afro-Brazilian *quilombola* communities; strengthening CONSEA's relationships with public agencies related to Food and Nutrition Security, such as SAN forums; support for the creation of Municipal Food and Nutrition Security Councils; drafting the Action Plan for Food and Nutrition Security Policies; implementation of training programs for council members, delegates and the general population; creation and implementation of a Data Base on government and non-government Food and Nutrition Security activities and programs, among other actions;

c) Social participation policy: promotion of participation by civil society; promotion of the election of the council members through forums; promoting links between CONSEAs with SAN Forum, other Councils and similar entities; sharing of training experiences; creation of tools for CONSEAs to exercise Social Control of The Family Grant Program; recognition of Management Committees and support for their formation; incorporation of Management Committees as a basis for the formation of Municipality Councils; creation and implementation of electronic networks as a way of integrating and democratizing information and promoting and increasing participation by civil society.

d) Monitoring, assessment and indicators: creation of a Technical Group to ensure and follow up on policies for specific populations and aspects of production, in particular, family farming; training of council and committee members in monitoring, assessment and indicators; incorporation of guidelines from food and nutrition security conferences;

e) Food sovereignty and international affairs: guarantee that SAN's main goal is Food Sovereignty: development of a social map of activities and diagnostics relating to the issues of hunger and food security; promotion and support for the introduction of community and school vegetable gardens; training of parents and government officials to work in community and school vegetable gardens; promotion of courses teachinghow to make full use of food items; inclusion of SAN concepts in the school curriculum;

f) Food production: promotion of better understanding of what Family Farming is; development of water- and environment-related activities, seminars, proposals, etc.; discussion on savannah (serrado) vegetation in the Centre-West region: a) rural and urban eating habits and the preservation of native plants, giving priority to family and community vegetable gardens as the production model; b) preservation of rural and urban water sources; promotion of community and school vegetable garden programs; introducing professionals into the schools to assist in food production;

g) Access to food: focus on access policy for ethnic, gender, generational and handicapped minorities; establishment of partnerships with supply centres for food reprovisioning and subsequent distribution: respect for regional diversity in food access policies; and

h) Health and nutrition: promotion of nutrition education for children, introducing the topic as a subject in school; integration of SAN policies with nutrition policies; changing school diets so they meet a certain proportion of children's daily needs; promoting a cultural movement to bring back former eating habits.

Creation of Family Grant Program

The Family Grant income transfer program was established by the Federal Government through Provisional Measure No. 132, of October 20, 2003, later turned into Law No. 10,836, of January 9, 2004, and regulated by decree No 5209, of September 17, 2004. This program associates the transfer of financial benefits with access to basic social rights – health, food, education and social assistance. Interministry Legal Directive No. 2509, of November 18, 2004, in turn, sets out responsibilities and rules for offering and monitoring health activities relating to meeting the conditions for families benefiting from the Program. It was intended for families in situations of extreme poverty (with a per capita income of less than R$ 100 a month) and brings together the administration and implementation of income transfer procedures and Single Federal Government Register activities. The unified programs were the School Grant from the Ministry of Education, Nutrition Grant from the Ministry of Health, Supplementary Food Program (PCA), and Gas Allowance from the Ministry of Mines and Energy.

With the MDS, emergency activities are carried out for specific groups (basic food baskets for landless families and indigenous and Afro-Brazilian *quilombola* communities), and also: i) the Program for Acquisition of Family Farming Produced Food (strategic stockpile replacement, incentive program for milk production and consumption); ii) Expansion of School Meals Programs; and iii) Food banks and food and nutrition education programs and programs oriented towards local policies managed by states and municipalities with Federal Government support, along with an organized civil society with the objective of supporting both urban and rural areas most vulnerable to food insecurity, using means such as people's restaurants, community kitchens and vegetable gardens.

An assessment of the performance of the Family Grant Program, one of the largest outreach programs for poor populations in Latin America, supported by the World Bank and reported in the *Folha de São Paulo* newspaper in 2006, shows that "comparison studies carried out by the World Bank demonstrate that 73% of program benefits reach the 20% poorest Brazilians," assisting 8.7 million families, and presenting the second largest budget among the current government's programs, some R$ 5.6 billion.

The greatest challenge to the Family Grant Program relates to the integration of its activities with other sector agencies, such as Health, Education, Labour, and Mines and Energy. According to the Citizenship and Income National Secretariat, the Family Grant Program has been prioritizing access by beneficiaries to other government programs, because *"since last year (2005), there has been an effort to integrate Family Grant and the Literate Brazil Program. The program already works as an integration point for others"* (CUNHA, 2006, FOLHA DE SÃO PAULO, 2006).

In addition to the education, health and social development programs mentioned above, there are other ongoing programs/activities related to food and nutrition. Among them, we might mention the following (BRAZIL, MS/CGPAN, 2005, pp. 176-184):

- "Farming and Agro-industrial Research and Development for Social Integration" Program developed by the Brazilian Agricultural Research Corporation (EMBRAPA), with the objective of building a base of scientific and technological knowledge regarding farming activities intended for small enterprises.
- Also developed by EMBRAPA, the "Food and Drink Safety and Quality" Program, for the purpose of guaranteeing food safety for consumers, considering the safety, quality and identification aspects of products and by-products of animal or vegetable origin, guaranteeing the quality of agricultural raw materials and promoting animal and vegetable health by using risk assessment, surveillance, control and phytozoosanitary inspection.
- Science and Technology for Social Integration/Support for Research and Development Applied to Food and Nutrition Security, a program developed by the Ministry of Science and Technology to support projects, studies, programs and activities to promote the development of food and nutrition security and social integration, and reduce regional inequalities.
- Food access/distribution for specific population groups, developed by the National Food Supply Corporation (CONAB), although present in the 2004 MYP, has been

implemented since April 2003, when CONAB was appointed the operational executive agency for the Zero Hunger Program (Interministry Directive MESA/MAPA No. 183/03). In a joint activity involving the Ministries of Social Development and Hunger Eradication (MDS), Ministry of Agrarian Development (MDA), Ministry of Agriculture, Livestock and Supply (MAPA), Ministry of Finance (MF) and the Ministry of Planning (MP), with the executive agencies CONAB and MDS.

- "Food Supply/Acquisition of Family Farm Products and Strategic Food Security Stockpiling Operation" Program, created July 2, 2003 (Law No. 10,696 and decree 4772), has been in operation since 2003 for the purpose of promoting family farming by purchasing their farm products and distributing them to people in situations of food insecurity and/or building up strategic stockpiles.

Chronic Noncommunicable Diseases (CNCD) under the PNAN and Their Nature as a Public Health Issue

According to one key informant, although they were announced or referred to superficially in PRONAN II, and much more forcefully in the National Food and Nutrition Policy (1999), CNCD have in fact become a government concern, involving several institutions, only in the last three years, since 2003.

Before PNAN, there were some programs related to chronic noncommunicable diseases implemented through the Ministry of Health, although they were,

> *"extremely fragmented. For example, in the 1970s, the National Cancer Department was already in existence. There were also some initiatives relating to hypertension and diabetes, and, more recently, after PNAN, there was a project to reorganize activities in the area of noncommunicable diseases and health conditions (DANTs), which resulted in a survey on the population at risk."*

INAN has developed many diet supplementation programs linked to the services of the basic health network, programs that attempted to intervene in the marketing of basic products, acquisition and sale of products at low prices in places where access to food is difficult, and supplementation of specific nutritional deficiencies such as anaemia, hypovitaminosis A, etc., as stressed by one stakeholder interviewed,

> *"these are historical programs for which we are trying to improve and expand coverage. For example, all salt consumed in Brazil is iodized. This is a problem that came to light many years ago, and today diseases resulting from iodine deficiency are practically nonexistent. Public policy requires manufacturers to add iodine to the salt we consume. Since this contributes to an improvement in the nutritional situation, it also contributes to the prevention of chronic noncommunicable diseases. We know that the relationship between nutrition and these diseases is very clear and direct."*

Another initiative also mentioned by another key informant was the CARMEN Project. This is a World Health Organization (WHO) project that was proposed even before PNAN, in 1999. Depending on the political environment, this project has carried out important action in the field of health. *At times, it flourished, at other times, it was almost dormant.*

PNAN represented an attempt to *"provide a certain logic behind all this, but it was not entirely successful."* There were initiatives, for example, for a project that worked to promote good eating habits and physical activity,

including support material for distance training, with participation by technical personnel and scientists from all over Brazil.

There were also initiatives in the Ministry of Sports with a view to stimulating physical activity, but they were completely dissociated from the Ministry of Health's initiatives, as this other key informant remembers,

> *"in the Ministry of Sports, there was the Institute of Sports. Pelé, if I am not mistaken, was the minister, and they organized physical activity programs and one activity in the area of nutrition and nutritional guidance, which was carried out by the National Food and Nutrition Institute (INAN). But there was no dialogue between the various sectors, in spite of INAN being part of the Ministry of Health and the fact that the materials used by the Ministry of Sports were created by the Ministry of Health itself."*

Within the Ministry of Health, in the opinion of one stakeholder, there was also, *"a small coordination group working on diabetes and hypertension, but it had little support. There were only three workers there and, although highly motivated, they formed a very small group."*

According to this stakeholder, prevention and control activity for diabetes and hypertension were not government priorities, in accordance with international health policies, because,

> *"to the international community, we are considered poor developing countries where hunger is still a problem. Prioritizing health problems resulting from opulence and excessive food and energy intake is therefore an enormous complication. For years, this small coordination has blocked discussion of diabetes, hypertension and cancer. Today, the area is still fragmented within the government. We have, for instance, the National Cancer Institute (INCA), which has been carrying out wonderful studies and producing some very high level reports about cancer, including in the area of nutrition."*

With respect to the creation of a Food and Nutrition Technical Sector, right after INAN was abolished, there is an emphasis on the definitive work it had done on the issue of food consumption. However, historically, it could be said that the,

> *"programs developed by ATAN were not as closely linked to the area of food and nutrition as they are today. One can observe, even in many studies by Professor Carlos Monteiro, a tendency for malnutrition to result in obesity. A large number of obesity cases began to be observed among very poor populations in rural and other areas, as also mentioned in several studies by Professor Malaquias Batista in Pernambuco and other researchers."*

Within the Ministry of Health, the problems of hypertension, diabetes and chronic noncommunicable diseases were not seen as related in terms of policies, or associated with the same health causal factors, such as the spread of healthy or unhealthy eating habits and lifestyles among the population as a whole. They were disconnected actions to deal with specific problems, which is one of the reasons why they did not move forward on government's public agendas and did not have the expected impact.

Nonetheless, when chronic noncommunicable diseases began to appear with greater frequency among the middle and upper classes, the government became concerned

about the need to promote healthy behaviour among the public, such as, for instance, basic health care. At the time, the obesity issue was placed at the tertiary care level and did not affect health centres.

On the other hand, in the health centres, there was a great demand for primary health care for cases relating to malnutrition and diarrhoea. More recently, these health centres have begun to work with hypertensive, diabetic and obese patients, even training health professionals to see unit patients and assigning doctors to these specific areas *"because until then, there were no doctors for that. Health centres were more dedicated to paediatrics and general practice. There was no one to look at chronic degenerative diseases."*

With the advent of the Global Strategy on Diet, the prevention and control of chronic noncommunicable diseases gradually became part of the Brazilian health agenda. Previously, the problem had been much more restricted to researchers dedicated to the epidemiological study of their occurrence, *"no thought was then given to the lower classes, who are mentioned so frequently when talking about obesity today."* Each region of the country presented a diagnosis, as one key informant reminds us.

It is worth pointing out that one of the first steps towards CNCD awareness took place in 1988, with a multicentric study on diabetes prevalence in Brazil. Later, with cooperation from the diet monitoring sector within the area of food and nutrition, the issue arose of the need for nationwide labelling to show the amount of fat, sugar, etc. contained in a product.

CNCD is one of seven PNAN guidelines. Promoting a healthy diet has a fundamental impact on CNCD prevention and control, affecting all other guidelines, so prioritizing it was important for the National Food and Nutrition Policy (PNAN), since it ushered in this new concept of concern about the chronic noncommunicable diseases that affect every phase of a person's life.

In this sense, this guideline calls attention to the fact that a concern for lifelong prevention and control must be incorporated into all Ministry of Health activities and programs , meaning that, from birth to old age, a healthy lifestyle must be promoted as a way of preventing chronic noncommunicable diseases and thus having a positive impact on epidemiological and nutritional indicators.

Despite not necessarily being described this way, this approach to the food and nutrition component is of great political concern. According to one key PNAN informant:

> *"In particular, I think it is necessary to promote healthy nutrition by focusing not only on the issue of chronic noncommunicable disease control and prevention, but also on health as a whole. Another thing I find essential is the question of physical activity. I have read articles showing that, in fact, hypertensive patients who begin regular exercise end up reducing their continued use of medications, and many even stop. PNAN has a lot to contribute in this area of promotion."*

Since 2004, with the implementation of the Global Strategy on Diet, the Brazilian Ministry of Health has prioritized food and nutrition related to chronic noncommunicable disease prevention and control guidelines. Some interviewees stated that this is a

political priority in the area of health, particularly, with respect to overweight and obesity problems. Brazil has approximately 3 million victims of malnutrition and 40 million people who are overweight or obese. These statistics impose a health promotion agenda for the country, since they are generally related, in public health and epidemiological terms, to diabetes, hypertension, and heart disease (BATISTA, 2005).

Within the Ministry of Health, the Global Strategy has been administered jointly by various sectors, and coordinated by the Health Surveillance Secretariat, through the General Coordination of Noncommunicable Diseases and Health Conditions (CGDANT) with the cooperation of the General Food and Nutrition Policy Coordinator (CGPAN), under SAS. It also involves other technical sectors of this Ministry such as the National Cancer Institute (INCA) and ANVISA.

In order to orient the Global Strategic activities, the Ministry of Health, by means of Legal Directive No. 1190, of July 14, 2005, established the National Health Promotion Policy Management Committee, considering the need to develop, strengthen and implement policies and action plans at the municipal, state and national levels that consolidate the health promotion component in SUS; considering health promotion a transversal articulation strategy capable of creating mechanisms to reduce public health risks and situations of vulnerability, defend equity, and incorporate social participation and control into public policy management; bearing in mind the goal of the National Health Promotion Policy to contribute to changing the care system model through the expansion and clarification of health promotion activities and creation of an integrated strategic agenda. It also considered the guidelines of the National Health Promotion Policy based on comprehensiveness, equity, health responsibility, mobilization, social participation, intersectorality, information, education, communication and sustainability.

The duties of the Management Committee mentioned above the following:

I– To consolidate the proposal of the National Health Promotion Policy;

II– To consolidate the Health Promotion National Agenda 2005-2007 in accordance with the policies, priorities and resources of each secretariat of the Ministry of Health and with the National Health Plan;

III– To articulate and integrate health promotion activities within SUS;

IV– To coordinate the implementation of the National Health Promotion Policy in the SUS and in its relationship with government and non-government sectors;

V– To encourage states, municipalities and the Federal District to develop Health Promotion Plans, considering the guidelines on the National Health Promotion Policy and the Health Promotion National Agenda; and

VI– To monitor and assess the implementation strategies of the National Health Promotion Policy and its impact on improving the quality of life of individual and community.

CGPNPS is made up 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 Strategic Management Secretariat (SGP);

IV– One delegate from the Labour and Health Education Management Secretariat (SGTES);

V– One delegate from the Science, Technology and Strategic Supplies Secretariat (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 full member of the National Health Promotion Policy Management Committee (CGPMPS) will suggest a substitute.

§ 2– Full members of CGPNPS and substitutes will be appointed by a legal directive of the Health Surveillance Secretariat.

§ 3– Members must declare that they have no conflict of interest with their activities with respect to the topics discussed by the Committee; in the event of a conflict of interest, they shall refrain from taking part in discussions and decisions on the topic.

CGPNPS has an Executive Secretariat, associated with the Health Surveillance Secretariat, responsible for its coordination.

It is the responsibility of the Health Surveillance Secretariat to adopt the measures and procedures necessary for the full functioning and effectiveness of the provisions of this legal directive.

In order to provide continuity in the activities resulting from Brazil's adoption of the Global Strategy, in 2005, a new Ministry of Health Legal Directive, No. 2608/GM, of December 28, 2005, set aside financial resources from the Health Surveillance Financial Ceiling to encourage the structuring of Noncommunicable Diseases and Health Conditions Prevention and Surveillance activities by State Health Secretariats and the Municipal Health Secretariats in the capitals. This is a very important tool in that

it develops public policies for the surveillance and prevention of noncommunicable diseases and health conditions, reducing risk factors related to sedentarism, improper diet and tobacco use, in accordance with the World Health Organization (WHO)'s Global Strategy on Diet, Physical Activity and Health and its Framework Convention on Tobacco Control.

Conclusions

The creation of PNAN was based on evidence of important questions concerning Brazil's food and nutrition profile on the basis of the assumptions presented at the World Food Summit.

At the time PNAN was formulated, the regulatory limits on food production, storage and labelling, food production subsidies and control over media advertising were just beginning to appear. With the arrival of globalization, Brazilians have increasingly been adopting Western eating habits, making it difficult for the Ministry of Health to focus on a broader policy than that of malnutrition.

Guaranteeing food safety and quality is still PNAN's major challenge. The promotion of healthy eating habits, the promotion of the right of access to food – how this guideline is operationalized implies a course of action by government that extends beyond the health sector. This intersectorality appears when we attempt to include the food industry in the implementation of measures related to the enrichment and/or modification of foodstuffs, such as the requirement that iodine be added to salt produced for human consumption.

PNAN was formulated on the basis of constitutional principles – food as a human right and a government duty is guaranteed in the legal text (Legal Directive No. 710, of July 11, 1999), However, the directive itself does not ensure the effectiveness of action. Food as a human right requires intersectoral efforts. Other requirements are an agreement on terminology, minimum knowledge of causality processes and causal factors relating to CNCD, i.e., the generation of quality data to assess policies and the causality networks of public health problems – today's great challenge.

A significant advance was the inclusion of the topic on the agenda with a view to formulating a public policy in the area of food and nutrition, with a regulatory framework (the Ministry Legal Directive), and kindling public awareness of CNCD prevention as one PNAN guideline (healthy nutrition and physical activity), in addition to the need for food labelling, obesity-related educational TV programs, etc.

It is important to point out that PNAN, considered by one of the key players to be "advanced and modern", was adopted as government policy, including with respect to implementation of its guidelines, as was the case with the Food Grant (2002-2003) and Family Grant (2004 to date).

The implementation of SISVAN, as a result of one of PNAN's guidelines, may be considered one of its virtues. SISVAN is dedicated to gathering information in support of public policies to improve the nutritional conditions of the population and to maintain a major sectoral convergence point in the public health sector.

The policy was formulated in a very participatory manner, not by accident, in the area of human resources. Food and nutrition professionals consider the policy a regulatory framework on the political, technical and ethical levels, as an action strategy for implementing its guidelines, initiating a major process for training administrators in all government spheres for the implementation of PNAN's activities.

Food and Nutrition and Surveillance teams concerned with CNCD must work jointly, in completely integrated fashion, keeping in view the implementation of the Global Strategy. In the end, they must work to ensure that the Ministry of Health's priorities in terms of policies and strategies benefit health promotion, since effectiveness in this area will diminish the demand for hospital or medical care and improve legislation governing health surveillance, even though there have already been great advances in this field in the past few years (in health surveillance, for instance).

Lessons Learned from the PNAN Creation Process – Brazilian Case Study

Some issues that deserve consideration and are important not only for the formulation of PNAN, but for other policies as well, are discussed below.

Contrary to common belief, the issue of food and nutrition has always been on the public agenda in Brazil, although the priority given to it and the capacity to deal with its complexity have changed from government to government.

The simultaneous processes of creation and implementation of public policies proved to be solid lessons learned, based on the search for democratic improvement: *"The process of formulating PNAN was very inclusive and consultative: at the same time, we tried to examine the programs, cancelling some activities and improving others,"* which resulted in a citizen participation process, making it possible to expand the discussion to civil society.

The lessons learned from the process of formulating PNAN and during implementation of its activities during the period from 1999 to 2005 included the influence of international organizations on the formulation and financing of Brazilian programs and policies, as well as their influence on values, ideas and knowledge among health professionals (physicians, nutritionists, nurses) themselves.

The process of formulating PNAN was the trigger for the formulation of other health policies at the Ministry of Health. It is important to point out that it was created and approved within a context of governmental crisis, which food and nutrition specialists and active supporters took advantage of to make strategic changes, turning the crisis into a window of opportunity in the way described by Kingdon (1995). From this perspective, the possibility of institutionalizing the Ministry of Health's proposal becomes clear - a regulatory and normative framework allowing policy development, the possibility of articulating a definition of the problem, with alternative solutions and the political priorities of the public administrators – as do decision-makers, the possibility of analysing the convergence of existing forces in a certain scenario and the margin of manoeuvre given to public administrators in the area 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.

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Appendixes

Appendix 1
National Food and Nutrition Policy (PNAN) Summary

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Política Nacional de Alimentação e Nutrição do Setor Saúde*

Secretaria de Políticas de Saúde

The Health Sector's National Food and Nutrition Policy*

Health Policies Secretariat

In 1999, the Ministry of Health implemented a series of basic measures for the sector, described in the National Food and Nutrition Policy (PNAN) formally approved by Legal Directive 710, published in the Official Gazette of the Union last June. Formulation of this National Policy was coordinated by the Health Policies Secretariat – which was also responsible for its implementation – with the participation of various governmental sectors, social strata and experts on the topic, after submission for appraisal to the Tripartite Inter-management Commission and the National Health Council.

The adoption of this Policy was a very important milestone since food and nutrition are basic requirements for promoting and protecting health. In the area of food and nutrition, Brazil is facing extreme situations: on one hand, malnutrition and lack of some essential micronutrients are still prevalent, while on the other hand, there are high and growing rates of obesity. Within the context of food and nutrition security, the goals of this National Policy are to guarantee the quality of food consumed in Brazil, promote healthy eating habits and prevent and control nutritional problems, as well as to provide an incentive to intersectoral activities that favour universal access to food.

The concept of food security, which was previously limited to supply, in the appropriate quantity, has been expanded to cover universal access to food and its nutrition aspects, and the resulting issues regarding composition, quality and biological benefits. Brazil adopted this new concept in 1986, with the First National Food and Nutrition Conference, and has been consolidating it since the National Food Security Conference, in 1994.

Agricultural credit, the assessment and adoption of industrial and agricultural technology, strategic stockpiles, cooperativism, imports, distribution, food storage and conservation, sustainable management of natural resources, etc. are some of the components of food and nutrition security. Therefore, action to guarantee this security extends far beyond the health sector and becomes intersectoral in nature, especially with respect to production and consumption, which includes the public's purchasing power and the choice of foods available for consumption, and also the cultural factors affecting such choices.

Both the adoption of the concept of security at a global level and the resumption of discussions on the topic on the part of the Brazilian government have made it easier to understand the role of the health sector with respect to food and nutrition. Within the context of food and nutrition security, the performance of the sector is marked by two moments, which might be called positive and critical, respectively.

The positive moment occurs when the offer, distribution and consumption of food, made possible by extra-sectoral means and with the participation of society, occurs normally in terms of quantity, quality and regularity, as well as in terms of biological use. Under these positive conditions, the principal activities of the health sector are food and nutrition surveillance, health and diet surveillance and education measures.

The critical moment occurs when there are gaps in the offer, consumption or patterns of biological use of food. Under these circumstances, extra-sectoral (lack of income, disruptions in production, variation in supply) or sectoral (for instance, lack of information and improper eating habits, as well as the presence of endemic diseases or health conditions) obstacles may lead to health problems: malnutrition, specific deficiencies, obesity, diabetes mellitus, dyslipidemias and combinations with other chronic diseases of recognized epidemiological relevance. Finding a solution to these problems falls to the health sector.

GUIDELINES

In order to attain PNAN's goals, seven essential guidelines have been established: stimulating intersectoral action targeting universal access to food; guaranteeing the safety and quality of food and providing related services, monitoring the food and nutrition situation, healthy eating habits and lifestyle, prevention and control of nutrition problems and diseases related to food and nutrition, promotion of the development of lines of investigation , and development and training of human resources.

With respect to **stimulating intersectoral action targeting universal access to food**, the Policy establishes that the health sector, as the possessor of epidemiological data regarding favourable and unfavourable aspects of food and nutrition, must promote closer liaison with other government sectors, civil society and the food production sector, whose activities are related to causal factors interfering with universal access to good quality food.

The basic strategies to **ensure the safety** and quality of products and provide food-related services will be the reorganization and strengthening of health surveillance activities. Such action is particularly important considering the continuous modernizing of production technologies, industrial processes, preserving, packaging and other aspects making up the supply and demand profile of the public's food supply.

Under the National Health Surveillance System, operational and technical standards relating to food and food-related services must be reviewed, emphasizing those related to the prevention of health problems. Inspection tools must be modernized by adopting production and service provision control and safety measures, particularly bearing in mind hazard analysis and critical-point control, aiming at preventing food-transmitted diseases and economic loss due to deterioration.

In addition, standards for rationalization, coordination and control of health surveillance procedures in all segments of the food chain, from the production phase through labelling, storage, transport, commerce, to the consumption stage, must constantly be reviewed. The modernization of national health legislation relating to food must be promoted, taking into account advances in biotechnology – transgenic and other processes – as well as the compatibility of monitoring procedures and criteria, in accordance with the legal instruments governing international agreements.

For the **monitoring of the food and nutritional situation**, the Food and Nutritional Surveillance System (SISVAN) must be expanded and improved, expediting procedures and expanding coverage to the entire country. SISVAN's activity will encompass the continuous description and prediction of trends in the public's food and nutrition conditions, as well as their causal factors. The descriptive and analytic diagnosis of the main

problems and causal factors must describe the geographic areas, social strata and biological groups at greatest risk.

In this monitoring, Sisvan must prioritize pregnant women and growing and developing children, and serve as the focus for all work in the service network, especially with respect to primary health care. The service network will also attempt to incorporate each user's nutritional situation into service routines in order to detect risk situations and prescribe activity that may facilitate prevention of their effects and ensure the return to normal.

Another priority must be the mapping of endemic deficiencies so as to reveal their spatial distribution and indicate the magnitude of the occurrence of protein-energy malnutrition (PEM), anaemia, hypovitaminosis A and iodine deficiency. With respect to chronic noncommunicable diseases associated with improper diet and lifestyles, work must be made compatible with the systems in operation in terms of the collection, production, flow, processing and analysis of data.

More specifically, information systems must focus on aspects related to breastfeeding practices and positive or negative interfering variables, as well as periodic assessments of the nutritional situation of public school students. The monitoring of food production and critical analysis of its supply and demand in terms of quality and quantity will also be essential points.

The **healthy eating practices** guideline is already incorporated within the context of adopting healthy lifestyles, an important component of health promotion. The dissemination of knowledge about food and nutrition must be emphasized, as well as the prevention of nutrition problems, from malnutrition — including specific deficiencies — to obesity. Action to foster healthy eating practices must include all measures consistent with the guidelines defined by the National Policy.

The return to regional eating habits and practices associated with the consumption of low cost and high nutrition-value local food products must be given a priority focus, along with more varied nutrition patterns, from the first years of life until adulthood and old age. In addition, particular emphasis must be given to chronic noncommunicable diseases, such as heart disease and diabetes mellitus, and the adoption of appropriate healthy eating habits by those suffering from them, as a way of avoiding further deterioration in their condition.

A review of methods and strategies will constitute the initial bottom-line measure for implementing the priority given to breastfeeding incentives, especially through contacts with various social sectors, particularly those with the greatest capacity to influence breastfeeding practices. The adoption of measures directed at creating rules governing advertising of food products directed towards children will also be very important. At the same time, on the basis of previously established criteria, institutional programs, such as "Babyfriendly Hospitals" and breast milk banks, must also be supported, as well as movements initiated by NGOs to encourage breastfeeding. Milk banks must be given special attention in order to support their activities and effectively incorporate them within health service routines.

With respect to legislation, legal directives ensuring basic conditions to allow mothers to breastfeed their babies, such as working hours and workplaces compatible with breastfeeding practices, must be strengthened, expanded and

publicized, along with the monitoring of manufacturing and marketing processes for pharmaceutical or diet products presented as therapeutic or prophylactic solutions to nutrition problems (weight control, fatigue, aging, prevention and treatment of difficult-to-manage diseases).

Implementation of the guideline related to the **prevention and control of nutrition problems and diseases related to food and nutrition** will involve action based on two polar-opposite situations, bearing in mind the lack of a clear division between institutional measures relating specifically to nutrition and conventional health interventions. In the first situation, a picture of morbidity and mortality prevails, dominated by the malnutrition/infection dyad that mainly affects poor children, particularly in socially and economically underdeveloped regions. In the second situation, there is a predominant group who are overweight or obese and suffering from diabetes mellitus, heart disease and some neoplastic diseases.

For the group with chronic noncommunicable diseases, measures will be directed towards health promotion and control of eating disorders, since these are the most effective way of preventing them. Food and nutrition problems relating to protein-energy malnutrition will be treated through a family approach, recognizing that risk factors arise within a context that could be termed "family at risk".

With malnutrition/infection, the emphasis shall be placed on activity aimed at prevention and appropriate management of infectious diseases. Food distribution and nutritional education will be indispensable, associated with the prevention and control of diarrhoea, acute respiratory infections and vaccine-preventable diseases, essential to avoid malnutrition or deterioration.

Monitoring growth and development will be adopted as the basis of support for all child health care activities, especially for those with low birth weight, due to high vulnerability to malnutrition and infectious diseases. Children at risk of malnutrition, between 6 and 23 months, will be treated with nutrition assistance, control of coexisting diseases, and monitoring of siblings or persons in contact, including pregnant women and breastfeeding mothers at nutrition risk, with emphasis on poverty belts.

Monitoring of the nutrition situation, fundamental to PEM prevention and control, will be incorporated into general assistance routines in a way that covers the whole age bracket at risk, and facilitates the identification and development of action to reduce moderate and acute infant malnutrition, decrease occurrences of anaemia and malnutrition in pregnant women, reduce the incidence of low birth weight, and follow up on those cases.

With respect to micronutrient deficiencies and in particular the control of iron deficiency, essential measures such as food enrichment, educational guidance and use of iron supplements must be adopted. To reduce iron deficiency anaemia, action must be undertaken to fortify part of Brazil's production of wheat flour and corn meal, which are low-cost and widely-consumed food products. The goal of these actions is to reduce iron-deficiency anaemia in preschool children by up to one third by 2003, keeping in mind the protocol already signed by the Brazilian government and the productive sector.

In the struggle against hypovitaminosis A, in known risk areas, in addition to the periodic emergency application of megadoses of retinol, incentives to produce and consume food products rich in this vitamin or its precursors must

also be promoted. Where necessary, some types of food must be fortified. In these risk areas, in addition to other precautions inherent in primary health care, children up to five years of age must be given massive doses of this particular nutrient. Enrichment of milk and pasta with Vitamin A, iron, or possibly other nutrients, must also be promoted.

Considering the epidemiological importance of deficiencies in these nutrients, the chemical and nutritional composition tables of the main types of food consumed in Brazil must be supplemented, enhancing the content and the availability of iron and vitamin A precursors.

Problems resulting from primary iodine deficiency must be dealt with by adding iodine to salt for domestic and animal consumption, and the legal, administrative, and operational conditions provided for systematic implementation of this measure. Continuous control measures must be systematized and implemented, either within the iodine addition process itself at the industrial level, or at the inspection stage when products are placed on the market for sale and consumption.

On the other hand, incentives for breastfeeding will be of strategic importance in preventing protein-energy malnutrition, anaemia and vitamin A deficiency during the first months of life, and reducing the incidence, duration and severity of diarrhoeas and acute respiratory infections. Efforts directed at expanding the breastfeeding period, so that exclusive breastfeeding continues until the child reaches six months, and breastfeeding combined with the introduction of appropriate foods continues until the second year of the child's life, shall be consolidated.

One of the mechanisms to guarantee that these actions take place will be the transfer of specific federal financial resources to the area of nutrition deficiencies and other problems. Municipalities qualified to carry out management activities as established by the Primary Operational Standard – Full Primary Care Management and Full Municipal System Management – may be accredited to receive a financial incentive linked to the Primary Care Floor (PAB), once they meet the criteria set. Resources will then be regularly and automatically transferred from the National Health Fund to the Municipal Health Fund. It is important to point out that, in accordance with the legal directive governing the financial incentives covering costs of food and nutrition-related measures, all activities to be carried out are defined, including those relating to the control of malnutrition in groups at risk.

Implementation of all National Food and Nutrition Policy guidelines must be supported by **lines of investigation** that will clarify specific and general aspects of certain problems, assess the contribution of the causal factors involved, and indicate the most suitable control measures. Lines of interest include the issue of protein-energy malnutrition, which despite being well described and analysed in geographical and social terms, requires additional study. Within the context of micronutrient malnutrition, broadening our still limited knowledge about anaemia and hypovitaminosis A's epidemiology merits special attention.

At the same time, the still preliminary studies on the relationship between chronic noncommunicable diseases and diet profile must be similarly expanded and their conclusions made public. In addition, the relationship between food consumption and diet value will be the subject of study to permit elaboration of

the situation analysis, since the available data refer to only a few metropolitan areas.

The studies and investigations should make it possible to develop national tables on the composition and nutritional value of foods and the principal ways they are prepared. These tables must in particular take into consideration the bioavailability of iron and vitamin A. The establishment of regional nutritional patterns for all ages, including the transition from breastfeeding to solids, in accordance with prevailing local habits, will also be emphasized, and efforts made to implement the projects already begun in this particular field.

Human resources training and development is one guideline that will affect all others defined in the National Food and Nutrition Policy (PNAN), as a preferred mechanism for intersectoral articulation, making it possible for the health sector to have personnel of the quantity and quality it requires. The joint work carried out with the Ministry of Education, specifically, will be made possible through the required adaptation of the health sector training courses in the light of all aspects of the PNAN guidelines.

More specifically, with respect to carrying out the activity, training will aim at preparing human resources to perform a basic set of activities, including case analysis, selecting beneficiaries and the required follow-up through local health services, and prevention and appropriate treatment of diseases that interfere with nutrition or, from another perspective, with food and nutrition conditions that may be relevant risk factors for the development of disease, in particular chronic noncommunicable diseases.

Training personnel to plan, coordinate and assess activities must form the basis for the development of a continuous process of articulation with other sectors whose activities are directly linked to food and nutrition. Professionals must be also trained to provide the proper technical cooperation when requested by other spheres of government, for the purpose of standardizing concepts and procedures.

RESULTS

In 1999, with the implementation of planned PNAN guidelines, more than R$130 million was invested. For that year, there was a budget of over R$176 million to be invested. The measures adopted in 1999 made it possible to attain relevant results, such as:

- Qualification of more than 86% of Brazilian municipalities — 4722 — to receive a financial incentive to combat nutritional deficiencies, referring to the variable portion of the Primary Care Floor (PAB);

- Regular service to more than 563 thousand children at nutritional risk between 6 and 23 months of age — i.e., 92% of the estimated total, receiving nutritional complements with high calorie and protein value;

- Regular service to 281 thousand children of other age groups, pregnant women and poor elderly persons, providing nutritional supplements and carrying out other appropriate nutrition activities;

- Distribution of four million megadoses of vitamin A to children between 6 and 59 months of age in endemic areas, such as the Northeastern region and the Vale do Jequitinhonha region;

- Distribution of 673 thousand bottles of ferrous sulphate by community health agents in 512 municipalities in the Northeastern region;

- Implementation of 15 nutritional studies and research projects for the national mapping of nutritional deficiencies and the development of Brazil's Food Composition Table;

- Development of nutritional guides reflecting regional diversity; preparation and distribution of informational materials on proper nutrition and healthy weight, targeting the general population and for the training of elementary teachers;

- Organization of database on food and nutrition, available for consultation through the Disque-Saúde [health information hotline], for which 80 operators were trained to provide information;

- Negotiation of agreements with states to reinforce food and nutrition coordination; and

- Iron enrichment of corn and wheat flour in accordance with the Social Commitment to Reduction of Iron Deficiency Anaemia in Brazil signed with the food industry.

*Technical Scientific Text from the Ministry of Health.

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Appendix 2
Interview Guide

SEMI-STRUCTURED INTERVIEW GUIDE
Procedures for the Formulation of a National Diet and Nutrition Policy

FORMULATION STAGE

1) In your opinion, when did the issue of food and nutrition first become part of Brazil's public agenda? Why?

2) In your opinion, what were the (political, economical, and social) factors that influenced the approval of PNAN in 1999?

3) Who were the stakeholders who contributed in any way to the formulation of the National Food and Nutrition Policy (public administrators of government institutions, Rights Councils, NGOs, universities, etc.)?

4) Did any public policy sectors other than the Health Sector take part in the discussions regarding formulation of the Policy?

5) Were National Food and Nutrition Policy guidelines discussed and negotiated? How?

6) What were the relevant concerns about the National Food and Nutrition Policy at the formulation stage?

7) Before the National Food and Nutrition Policy was created, were any programs, projects or activities to prevent and control CNCDs implemented/carried out at the federal level? What were they?

8) Did these programs achieve any results? Why were they changed? Who decided to make the changes?

9) What priority was given to the prevention and control of chronic noncommunicable diseases associated with food and nutrition? Why was that level of priority given?

10) What priority issues and strategic options were identified in the proposal for CNCD prevention and control in the National Food and Nutrition Policy?

11) What were the main obstacles or challenges to the process of creating a proposal for the prevention and control of food and nutrition-related chronic noncommunicable diseases?

12) Was any demand or sector not considered by the proposal? Why not?

13) In your opinion, what was the greatest merit of the CNCD control and prevention proposal in the National Food and Nutrition Policy?

14) In your opinion, what is the greatest weakness of the CNCD control and prevention proposal in the National Food and Nutrition Policy?

Appendix 3
Free and Informed Consent Form

Dear Sir/Madam,

We hereby request your consent to participation in the survey being conducted 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: Support for the formulation of a national policy on integrated surveillance,"** coordinated by the Health Surveillance Secretariat, National Coordination of Noncommunicable Diseases and Health Conditions, Ministry of Health, under the advisory of Dr. Denise Bomtempo Birche de Carvalho of the University of Brasilia.

The objectives of this survey are the following: i) to map government initiatives for the prevention and control of chronic noncommunicable diseases (CNCD) at the federal level in Brazil for five main components of public health. These are the National Food and Nutrition Policy; the national tobacco prevention and control policy; diabetes/ hypertension treatment; the promotion of physical activity, and surveillance; and, ii) to analyse the process of formulating initiatives in the area of public action to protect and promote health. The data will be analysed on the basis of the reconstitution of political fundamentals and criteria present in the decision-making process in formulating initiatives regarding the prevention and control of chronic noncommunicable diseases.

All those taking part in this study were identified after a broad survey relating to chronic disease prevention, control and surveillance as being key informants due to their active participation, knowledge and experience. This is why their contribution to reconstituting the process of formulating public policies in the area of chronic diseases in Brazil is vitally important for this study.

If you agree to cooperate in this survey, we will ask you to devote some time to an interview designed to become familiar with your perspectives as a stakeholder involved in the process of formulating and approving the policy with reference to one of the five components of the survey.

The interview will last about 90 minutes and will take place in a suitable place that provides privacy to protect your anonymity, and at a time to be agreed upon. Due to the characteristics of the study, more than one meeting may be required for the objectives of the survey to be met. The interviews will be carried out by two qualified interviewers: one to ask questions and the other to take notes. The interviews will be recorded, with your consent, which will allow the interviewers to gather the maximum amount of information from your contribution. However, if you consider that some part of your contribution was not recorded in the tape, you may inform the interviewers. The interviews will later be transcribed by qualified personnel.

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

The results of the research may be disclosed or published nationally or internationally in scientific reports or documents. No name will be used in disclosing the research results.

You will not incur any costs as a result of your participation in this study. Furthermore, no potential risks or benefits have been identified as possible consequences of your participation. However, your participation will of course be very valuable for the development of public health in this country.

Your participation is voluntary, and you are entitled to refuse to participate or to drop out of the project at any time you wish. A refusal to participate in the study would not involve any penalty or interfere in your relationship with the interviewers or participating institutions. You will have access to the final results of the research.

If you require further information on the study, please contact us at the telephone numbers below.

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Health Surveillance Secretariat
Ministry of Health
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I, _____ , have read and understood the explanations given in the above letter regarding the survey being carried out by the Ministry of Health, Health Surveillance Secretariat (SVS) entitled ***"Mapping of surveillance, prevention and control initiatives for chronic noncommunicable diseases in Brazil, 1999-2005: Support for the formulation of a national policy on integrated surveillance",*** *coordinated by the Health Surveillance Secretariat, General Coordination of Noncommunicable Diseases and Health Conditions, Ministry of Health, advised by Doctor Denise Bomtempo Birche de Carvalho of the University of Brasilia.*

I understand that I will take part in an interview lasting approximately 90 minutes, which will be recorded and transcribed. In addition, I may obtain an advance copy of the topics to be discussed in the interview if I wish. I also understand that the information I provide will be kept confidential and that the analysis will be disclosed or published nationally and internationally.

I have been informed that there are no known risks to my participation in this study and that I will incur no expenses. Furthermore, I may decide not to participate in the survey or even abandon it at any time if I so wish.

I have read and understood the information letter and this Consent Form. I know that I may contact the study coordinators at the telephone numbers provided if I need to obtain more information on the development of the research.

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

RESPONDENT'S NAME	ID NO	SIGNATURE
WITNESS	ID NO.	SIGNATURE
COORDINATOR'S NAME	ID NO.	SIGNATURE

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