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A look at the food and nutrition agenda over thirty years of the Unified Health System

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Abstract *Food and nutrition are basic requirements for the promotion and protection of health. Nutrition monitoring and dietary recommendations are included in the mission of the Unified Health System (SUS, in its Portuguese acronym), as established by the Organic Health Law no. 8,080 of 1990. This article presents and discusses the food and nutrition agenda of the SUS and its interface with Food and Nutrition Security, its benchmarks, progress and challenges. This essay was guided by biographical and documentary research and, above all, by the experiences and perceptions of the authors, who, at various times and in various contexts, have been and continue to be actors of Brazil's food and nutrition agenda. We emphasise the idea of the SUS, with its accomplishments and shortcomings, as a living system derived from the technical, ethical and political commitments of its administrators, workers, academics and society as a whole. Thus, we seek to contribute to the debate about the Brazilian path to the construction of a public social welfare system committed to health and adequate nutrition as a human rights.*

Key words *Food and nutrition programmes and policies, Health promotion, Nutritional transition, Unified Health System, Food and Nutrition Security*

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Introduction

In Brazil, the right to health and food are included among the constitutionally guaranteed social rights. Adequate food is a basic requirement for the promotion and protection of health, being recognised as a crucial and determining factor in the health of individuals and communities[1].

Seen as both a component of the Health Ministry's mission and an expression of the social actors historically engaged with this subject, food and nutrition were a major focus of the discussions on public health reform and the establishment of the Unified Health System (Sistema Único de Saúde, or SUS, in its Portuguese acronym)[2]. An example of this was the first National Food and Nutrition Conference, held in 1986, as a consequence and immediate follow-up to the 8th National Health Conference. On the one hand, this conference represented the involvement of the field of food and nutrition with public health reform; on the other hand, it launched a set of proposals that became permanent reference points in Food and Nutrition Security[3].

Thus, the food and nutrition agenda has been proposed and defended across other health campaigns, having been formulated, implemented and evaluated within the activities and responsibilities of the health system but also having bordered and intersected with the broad inter-sectoral field of Food and Nutrition Security[4].

According to the Organic Health Law, the mission of the SUS includes nutrition monitoring and dietary recommendations[1]. Based on this understanding and initial commitment, it was possible to go further and propose a topic-specific policy, the National Food and Nutrition Policy (PNAN, in its Portuguese acronym), which was adopted in 1999 and updated in 2011[5,6]. This policy guides the organisation and supply of nutritional care for the purpose of *improving the conditions of food, nutrition and health for the Brazilian population through the promotion of appropriate and healthy dietary practices; monitoring food and nutrition; and preventing and caring for diet- and nutrition-related illnesses, contributing to the formation of an integrated, effective and humane care network*[6].

Over the course of its thirty-year inclusion in the SUS, this topical agenda has gradually moved from its peripheral or parallel role to a clearer position as a leading and essential component of comprehensive health care. It therefore appears as a powerful link in the connection between health and other sectors related to the Human Right to Adequate Food.

This article, in the form of an essay, presents and discusses the food and nutrition agenda in the SUS and its interface with Food and Nutrition Security as well as its benchmarks, progress and challenges. To do so, we draw on biographical and documentary research and, above all, on the experiences and perceptions of the authors, who, at different times and in various contexts, have been and continue to be subjects of the Brazilian food and nutrition agenda. We emphasise the idea of the Unified Health System, with its accomplishments and shortcomings, as a living system derived from the technical, ethical and political commitments of administrators, workers, academics and society as a whole. Thus, we seek to contribute to the debate on the Brazilian path to the construction of a public social welfare system committed to health and adequate nutrition across sectors as a human right.

What came with the SUS?

First, one must recognise that the food and nutrition agenda in Brazilian public policies antedates the SUS. Its origin dates back to the 1930s and is characterised, on the one hand, by the emergence of the labour-oriented thought of the Vargas government and, on the other hand, by Josué de Castro's pioneering academic denunciation that hunger and its various manifestations in the human body (such as malnutrition and micronutrient deficiencies) were the consequence of social inequalities deriving from an unjust and exclusionary economic model. Since then, the Brazilian state has experimented with different forms of intervention and social programmes in the field of food and nutrition[7-9].

An historic event was the creation of the National Food Commission (CNA) in 1945 to coordinate the initial efforts to formulate a national food policy. An example of a CNA initiative was the 1953 enactment of the first law mandating the iodination of table salt in areas where goitre was endemic. However, the strategic role foreseen for the CNA only came into being with the creation of the National Institute for Food and Nutrition (INAN) in 1972 as an independent public agency linked to the Ministry of Health. Despite its sectoral link, it became an advocate for nutrition as central to national development and proposed inter-sectoral initiatives to respond to the food needs of the Brazilian populace, along the lines of compensatory policies and policies that promote social welfare. Paradoxically, the INAN emerged as a central strategic agency at the heart

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of the government during the military dictatorship. The weakening of the INAN's political and technical role led to its elimination in 1997, and some of its duties were taken over by technical areas of the Ministry of Health[7-9]. These experiences and socio-political constructions shaped the way the topic of food and nutrition appears in the SUS agenda.

Though implemented within the SUS, the PNAN emerged in 1999 as a public policy aimed at combatting the food and nutrition insecurity faced by the Brazilian population. The first version of the PNAN was pioneering in its adoption of the principle of the Human Right to Adequate Food. In response to the policy recommendations of the First National Food and Nutrition Conference and the First National Food Security Conference in 1994, the PNAN broadened the concept of Food and Nutrition Security from the existing narrow view of supplying appropriate quantities to include universal access to food and the nutritional aspects related to its composition, quality and biological utilisation, as well as the public health risks attributable to food. The first version of the PNAN was founded on guaranteeing food and nutrition security and taking an inter-sectoral approach[5,10,11].

During the decade following the publication of the PNAN, a set of political and legal benchmarks in the field of Food and Nutrition Security were approved, such as the 2006 publication of the Organic Law of Food and Nutrition Security and the establishment of the National System of Food and Nutrition Security (SISAN). In turn, changes in the epidemiological scenario highlighted the need to reorganise the Brazilian health system to meet the new demands of the population's health, which was marked by the emergence of chronic conditions. Thus, the innovations in the mechanisms of organising and managing health care adopted by the SUS, with the formation of Health Care Networks and the health care sector's duty to promote Food and Nutrition Security through the SISAN, guided the process by which the PNAN was revised between 2010 and 2011.

The SUS was considered to have made significant progress in the health care of the Brazilian population, such as the reduction of infant mortality, the expansion of primary care, the broadening of access to activities and services ranging from immunisation to transplants, including health monitoring and promotion[12]. However, challenges remained in terms of overcoming gaps in care and revising the care model with a view to providing comprehensive care in a complex epidemiological scenario that combines acute and chronic conditions[13,14], requiring overcoming a health care model that was fragmented, hierarchical and focused on acute conditions[15]. Thus arose the need to update the PNAN guidelines to guide the organisation and qualification of food and nutrition-related activities in the SUS and to legitimize it as the interlocutor between the SUS and the SISAN.

If the publication of the PNAN in 1999 represented a milestone for Food and Nutrition Security in Brazil by introducing issues such as the Human Right to Adequate Food and inter-sectoral nature of food and nutrition activities, its updated text emphasised nutritional care as a core component in the provision of health care. The concept of nutritional care includes the threefold task of monitoring food and nutrition, promoting appropriate and healthy diets and preventing or controlling nutritional problems[6,16].

The organisation charged with nutritional care within the SUS has faced challenges common to health care provision in general, especially with regard to primary care. As in other areas, such as paediatric care or hypertension control, nutritional care has evolved gradually from vertically structured programmes to a comprehensive care framework. Throughout its history in the SUS, food and nutrition-related activities were strongly marked by programmes designed to respond to a specific health problem in a certain population, such as programmes for preventing and controlling micronutrient deficiencies and linking food and nutrition monitoring to programmes that redistribute income and combat malnutrition. Their vertical structure, often parallel to the implementation of the work performed by health teams, is one of the factors explaining these programmes' limited coverage[17,18]. Gomes and Pinheiro[19] underscore that, among other things, comprehensive health care means a new way of organising care practices in the health services, which would require "a certain 'horizontalisation' of previously vertical programmes designed by the Ministry of Health to overcome the fragmentation of activities within the health centres".

A concrete example of the recent search for comprehensiveness in the food and nutrition agenda is the proposal of a line of care for prevention and control of obesity and excessive weight in the Health Care Network for People with Chronic Diseases (Ordinance nº 424 GM/MS of 19 March 2013), one of the products incor-

porated into the *Strategic Action Plan to Combat Non-Communicable Chronic Diseases*, launched by the Ministry of Health in 2011[20,21]. This line of care establishes and organises a set of activities and services involving a variety of actors in the health network care centres. The proposal for this line of care fostered communication and cooperation among the various care centres in the state and municipal health networks. Despite these advances, the publication of Ordinance nº 62 GM/MS of 6 January 2017, amending Ordinance No 424/2013, represented a step backwards in that it severed the link between the hospital's license to provide advanced care to obese individuals and the mandatory approval of the line of care as a whole. This represented a setback to the organisation of comprehensive care for obesity, especially with regard to the supply of activities and services through other points in the health care network, beyond in-hospital surgical care. Abandoning the commitment to organise nutritional care for obese and overweight individuals through the health care network represents a reversal in the construction of a comprehensive line of care, which could result in new practices in nutritional care.

With the recent shift in the organisation of nutritional care, due in large part to cuts in public spending on health[22], what stands out currently is the focus of debate on strategies for the prevention and control of excessive weight and obesity through nutritional labelling under the regulatory agenda of the Brazilian Health Regulatory Agency (ANVISA). This discussion is important and has been largely driven by the social movements that advocate for appropriate and healthy food. The prevention of obesity as a public health problem must necessarily be addressed through health regulation, understood here from the perspective of a broader concept of health risk with regard to food that goes far beyond certifying its physical, chemical or microbiological safety, spanning aspects related to monitoring the nutritional quality of industrialised foods to advertising and labelling policies; this includes communication and health education practices to raise health consciousness among consumers and social actors in the food system. Other Latin American countries have made efforts in this direction and have achieved promising results, such as the taxation of sugary drinks in México[23] and nutrition labelling with warnings about critical nutrients adopted in Chile[24].

In addressing the food and nutrition agenda in the SUS, it is important to acknowledge the fine line that separates intra- and inter-sectoral activities. For example, regarding the issue of funding, it is difficult to ascertain how much is invested in public policies on food and nutrition[25]. This difficulty is due to a variety of factors, including the inter-state generation and management of funding resources for public health and the inter-sectoral nature of the nutrition and food security agenda. Since the publication of the first edition of the PNAN, Brazil's federal government has been the main funder of activities and programmes specifically related to food and nutrition in the SUS; this occurs, in particular, through the purchase of supplies such as mineral and vitamin supplements or through the direct transfer of funds to states and, to a lesser extent, some municipalities. This transfer of federal funds establishes financial incentives for state and municipal health departments to set up and implement activities that support food and nutrition as recommended by the PNAN, and the utilisation of these funds often presents a challenge. In any event, although small in monetary terms, this funding incentive represents significant progress over the traditional, vertically structured, centrally implemented pre-SUS programmes, and the technicians who work on food and nutrition issues in state and municipal health departments recognise the importance of incentives in strengthening the field within the SUS, increasing its visibility and contributing to the implementation of some of the activities recommended by the PNAN guidelines[26]. It is worth mentioning that the allocation of resources in the form of *caixinha* within the federal funding has been vehemently criticised by states and municipalities. It should be borne in mind that the SUS activities related to food and nutrition cut across and comprise health care at different points in the health network and are also part of epidemiological and public health monitoring and on-going education, so they can receive funding through those programmes if they are incorporated as a component of comprehensive health planning. Thus, it is imperative that the issue of food and nutrition be accounted for in the budget as a conditioning and determining factor in health rather than as a specific programmatic agenda and that it does not depend solely on health.

Has nutritional transition driven the food and nutrition agenda in the SUS?

Over the course of the 30 years of the SUS' development, Brazilian society has undergone major social transformations that have changed patterns of food consumption, nutrition and health[16,27].

In the positive sense, this has included efforts by economic and social policy-makers to combat poverty and increase the income of Brazilians, which, together with improved access to health and education services, has affected how Brazilians live, get sick and die, resulting in a positive impact on health in Brazil[13,28].

The nutritional transition is related to a complex series of changes in demographic, socioeconomic, environmental, agricultural and health patterns, involving factors such as urbanisation, economic growth, income distribution, incorporation of technology and cultural changes[29]. Food systems, including the processes of food production, processing, distribution, marketing and consumption, are closely related to nutritional transition and need to be repositioned not only to provide food but to also promote healthier and more sustainable diets for all[30].

Overcoming child malnutrition as a public health phenomenon was a milestone in the history of the SUS and Brazilian social policy since the Constitution of 1988. Public programmes to combat malnutrition in Brazil advanced from palliative-welfare models to attacking its root social causes, as well as improving the quality of children's health care; these measures yielded positive results. The main factors identified as responsible for this improvement are as follows: more education for mothers; increased purchasing power for families; better access to essential public services; and improvements in sanitation. In the period from 1996-2006, the decline was more closely related to the increase in families' purchasing power, especially after 2003 with the expansion in coverage of income redistribution programmes, together with a significant expansion of access to public education and primary health care services. An analysis of the evolution of the state of child nutrition over recent decades shows a clear trend towards reduction of the huge social inequalities in the distribution of child malnutrition[31].

The model of conditional income transfer represented a paradigm shift in government intervention in the field of food and nutrition. The first initiative was the Food Stipend Programme (PBA) in 2001, which was replaced by the Family Stipend Programme (PBF) in 2003[32]. The PBF has affected the health and living conditions of the families that receive it in terms of better access to primary health care and related services[33] and reduction in low birthweight[34], malnutrition[35,36] and infant mortality[28].

Some less desirable results of the Brazilian nutritional transition are that the fall in malnutrition rates has been accompanied by a rise in other nutritional problems, such as the significant and progressive increase in overweight and obesity[37] and chronic non-communicable diseases (CNCDs) related to food and excess weight[14].

Dietary practices and habits have become important determinants of CNCDs in the country, prompting the development of food and nutrition education as a strategy to be valued in public policies related to health and food and nutrition security[20,38]. The Ministry of Health has published dietary recommendations for the purpose of presenting guidelines to promote appropriate and healthy eating[39-41].

Thus, the nutritional transition process in Brazil brought with it the challenge of updating the food and nutrition agenda in the SUS. The nutritional transition brought the food and nutrition agenda closer to the health services, facilitating its recognition as a component of comprehensive health care. In turn, understanding the social determinants of health that affect how Brazilians eat and the risks related to the nutritional state of individuals and groups highlights the need for responses that go beyond the health sector.

What is there beyond the SUS?

In a review of the history of Brazilian social policies that seeks links among food production, supply, consumption and nutrition, it can be observed that until the end of the last century, the health sector took a leading role in proposing answers to the issues of food and nutrition insecurity facing the population[7,8]. This may perhaps be explained by the fact that the health services bear the brunt of the problems caused by hunger, as expressed by malnutrition and by a food system that fails to promote health and produces illnesses related to an inappropriate diet, such as obesity.

However, guaranteeing Food and Nutrition Security requires a set of public social policies that are integrated and complementary. Following the establishment of the SUS, the first attempt

to raise the debate about Food and Nutrition Security to the level of the inter-sectoral political arena occurred with the 1993 establishment of the First National Council on Food Security (CONSEA). However, due to the transitional nature of President Itamar Franco's administration and the fragile integration of the topic of Food and Nutrition Security into the Brazilian political agenda, the CONSEA was disbanded in 1994, a year after its formation[7,8].

Efforts at inter-sectoral coordination were renewed in 2003 with the re-establishment of the CONSEA, the government commitment to prioritise Food and Nutrition Security, the institutionalisation of the National Policy on Food and Nutrition Security and the coordinated implementation of policies to promote social welfare and family farming. These factors are recognised as being responsible for progress in combating hunger and poverty in Brazil[42]. Thus, the pattern of intermittent and fragmentary efforts is giving way to a new paradigm in the formulation of public policies related to Food and Nutrition Security[43]. This spectrum includes progress in the National School Food Program and its interface with programmes for public purchases of food, among other examples[44].

Along these lines, it is worth noting the guidelines of the Fifth National Conference on Food and Nutrition Security, which adopted the motto "*Real food in the countryside and in the city: for food rights and sovereignty,*" highlighting the socio-cultural aspects of food and the value of a just and sustainable food system, from both a social and environmental perspective, where agrobiodiversity and traditional dietary patterns are protected and valued, with respect for sustaining identities, memories and dietary cultures unique to the Brazilian population, in accordance with the guidelines of the Food Guide for the Brazilian Population, published in 2014, which is a tool for health education proposed within the SUS[40].

Food and nutrition in the SUS: An agenda for the future?

The area of food and nutrition has taken a remarkable path towards greater dialogue and appropriation by the SUS. However, Brazil's progress in reducing hunger and malnutrition, along with the nutritional transition marked by changes in food consumption patterns, pose new and complex challenges to the system. The current and future agenda of healthy eating should incorporate the aspect of sustainability, in agreement with the goals set out by the 2030 agenda. It is worth noting that food is related to almost all the Sustainable Development Goals, which depend on changes in the food system to be achieved[45]. The priorities established include the following: improving access to and the quality of health care in terms of the comprehensiveness of care and broadening the understanding of people's true health and nutritional needs; promoting changes in the food system to foster healthy and sustainable dietary practices; promoting educational activities and the control and regulation of food (such as regulating food advertising and labelling and limiting critical levels of nutrients such as sodium in processed foods); consolidating models of inter-sectoral and participatory governance designed to change the food system and promote health and food and nutrition security; advancing the integration of social policies to reach targeted groups in the public sphere having diverse needs; and, finally, seeking out policies to ensure rights and access to healthy and sustainable food in at-risk areas such as food deserts.

However, this challenging process has been interrupted. Brazil stands at a crossroads in the development of a social welfare net that, until now, has sustained the achievements made in the food and nutrition agenda. Measures such as Constitutional Amendment 95, which establishes a spending ceiling that directly impacts SUS, together with cuts in social spending on education, social and agrarian development and reforms that impact the population's income, including revisions to labour and pension laws, endanger the recent advances in Health, Nutrition and Food and Nutrition Security[22]. It is likely that we will soon face a worsening of the double burden of malnutrition, hunger and undernutrition, aggravated by overweight and obesity due to a food system based on the production cycle of agribusiness and processed foods. This would represent a return to the historical problems of the past century, exacerbated by the new problems of the 21st century. In this worst-case scenario, how can we ensure that the SUS continues to build its capacity to accommodate the complex nutritional needs of the Brazilian population?

Collaborations

PC Jaime, DCC Delmuè, T Campello participated in conceiving the article PC Jaime was responsible for the writing. DCC Delmuè, T Campello, DO Silva and LMP Santos contributed to the text and critically reviewed the article. All authors approved the version for publication.

References

1. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União* 1990; 19 set.
2. Vasconcelos FAG, Batista Filho M. História do campo da Alimentação e Nutrição em Saúde Coletiva no Brasil. *Cien Saude Colet* 2011; 16(1):81-90.
3. Instituto Nacional de Alimentação e Nutrição (INAN). Ministério da Saúde (MS). *Conferência Nacional de Alimentação e Nutrição: relatório final*. Brasília: INAN, MS; 1986.
4. Alves KPA, Jaime PC. A Política Nacional de alimentação e Nutrição e seu diálogo com a Política Nacional de Segurança alimentar e Nutricional. *Cien Saude Colet* 2014; 19(11):4331-4340.
5. Brasil. Ministério da Saúde (MS). Secretaria de Políticas de Saúde. Departamento de Formulação de Políticas de Saúde. *Política Nacional de Alimentação e Nutrição.* Brasília: MS; 2000.
6. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. *Política Nacional de Alimentação e Nutrição.* Brasília: MS; 2012.
7. Pinheiro ARO. Reflexões sobre o processo histórico / político de construção da lei orgânica de segurança alimentar e nutricional. *Segurança Alimentar e Nutricional.* 2008; 15(2):1-15.
8. Vasconcelos FAG. Combate à fome no Brasil: uma análise histórica de Vargas a Lula**.** *Rev Nutr* 2005; 18(4):439-457.
9. Arruda BKG, Arruda IKG. Marcos referenciais da trajetória das políticas de alimentação e nutrição no Brasil. *Rev Bras Saude Mater Infant* 2007; 7(3):319-326.
10. Recine E, Vasconcellos AB. Politicas nacionais e o campo da Alimentação e Nutrição em Saúde Coletiva: cenário atual. *Cien Saude Colet* 2011; 16(1):73-79.
11. Pinheiro ARO. A alimentação saudável e a promoção da saúde no contexto da segurança alimentar e nutricional. *RSD* 2005; 29 (70):125-139.
12. Paim J, Travassos C, Almeida C, Bahia L, Macinko J. The Brazilian health system: history, advances, and challenges. *Lancet* 2011; 377(9779):1778-1797.
13. Victora CG, Barreto ML, do Carmo Leal M, Monteiro CA, Schmidt MI, Paim J, Bastos FI, Almeida C, Bahia L, Travassos C, Reichenheim M, Barros FC; Lancet Brazil Series Working Group. Health conditions and health-policy innovations in Brazil: the way forward. *Lancet* 2011; 377(9779):2042-2053.
14. Schmidt MI, Duncan BB, Azevedo e Silva G, Menezes AM, Monteiro CA, Barreto SM, Chor D, Menezes PR. Chronic non-communicable diseases in Brazil: burden and current challenges. *Lancet* 2011; 377(9781):1949-1961.
15. Magalhães Júnior HM. Redes de Atenção à Saúde: rumo à integralidade. *Divulg saude debate* 2014; 52:15-37.
16. Jaime PC, Santos LMP. Transição nutricional e a organização do cuidado em alimentação e nutrição na atenção básica em saúde. *Divulg saude debate* 2014; 51:72-85.
17. Almeida ER, Carvalho AT, Nilson EAF, Coutinho JG, Ubarana JA. Avaliação participativa do Programa Nacional de Suplementação de Vitamina A em um município da Região Nordeste do Brasil. *Cad Saude Publica* 2010; 26(5):949-960.
18. Nascimento FA do, Silva AS da, Jaime PC. Cobertura da avaliação do estado nutricional no Sistema de Vigilância Alimentar e Nutricional brasileiro: 2008 a 2013. *Cad Saude Publica* 2017; 33(12):e00161516
19. Gomes MCPA, Pinheiro R. Acolhimento e vínculo: Acolhimento e vínculo: práticas de Acolhimento e vínculo: integralidade na gestão do cuidado em saúde em grandes centros urbanos. *Interface (Botucatu)* 2005; 9(17):287-301.
20. Malta DC, Morais Neto OL, Silva Junior JB. Apresentação do plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis no Brasil, 2011 a 2022. *Epidemiol Serv Saude* 2011; 20(4):425-438.
21. Jaime PC, Silva ACF, Gentil PC, Claro RM, Monteiro CA. Brazilian obesity prevention and control initiatives. *Obes Rev* 2013; 14(Supl. 2):88-95.

22. Paiva AB, Mesquita ACS, Jaccoud L, Passos L. *O novo regime fiscal e suas implicações para a política de assistência social no Brasil*. Brasília: IPEA; 2016. Nota técnica nº 27.
23. Colchero MA, Molina M, Guerrero-López CM. After Mexico Implemented a Tax, Purchases of Sugar-Sweetened Beverages Decreased and Water Increased: Difference by Place of Residence, Household Composition, and Income Level. *J Nutr* 2017; 147(8):1552-1557.
24. Pérez-Escamilla R, Lutter CK, Rabadan-Diehl C, Rubinstein A, Calvillo A, Corvalán C, Batis C, Jacoby E, Vorkoper S, Kline L, Ewart-Pierce E, Rivera JA. Prevention of childhood obesity and food policies in Latin America: from research to practice. *Obes Rev* 2017; 18(Supl. 2):28-38.
25. Carvalho G. O financiamento federal de ações e serviços de alimentação e nutrição em saúde. In: Brasil. Ministério da Saúde (MS), Ação Brasileira pela Nutrição e Direitos Humanos (ABRANDH). *Textos de opinião: temas estratégicos para a política nacional de alimentação e nutrição (PNAN)*. Brasília: Organização Pan Americana de Saúde; 2011. p. 31-64.
26. Reis CS. *Avaliação da utilização do repasse fundo a fundo para estruturação e implementação das ações de alimentação e nutrição* [dissertação]. Brasília: Universidade de Brasília; 2015.
27. Batista Filho M, Assis AM, Kac G. Transição nutricional: conceito e características. In: Kac G, Sichieri R, Gigante D, organizadores. *Epidemiologia Nutricional*. Rio de Janeiro: Fiocruz, Editora Atheneu, 2007. p. 445-460.
28. Rasella D, Aquino R, Santos CAT, Paes-Sousa R, Barreto ML. Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities. *Lancet* 2013; 382(9886):57-64.
29. Popkin BM. An overview on the nutrition transition and its health implications: the Bellagio meeting. *Public Health Nutr* 2002; 5(1A):93-103.
30. Global Panel on Agriculture and Food Systems for Nutrition. *Food systems and diets: Facing the challenges of the 21st century*. London: WHO; 2016.
31. Monteiro CA, Benicio MH, Conde WL, Konno S, Lovadino AL, Barros AJD, Victora CG. Narrowing socioeconomic inequality in child stunting: the Brazilian experience, 1974-2007. *Bull World Health Organ* 2010; 88(4):305-311.
32. Campello T, Neri MC, organizadores. *Programa Bolsa Família*: *uma década de inclusão e cidadania*. Brasília: Ipea; 2013.
33. Facchini LA, organizador. *Perfil epidemiológico dos beneficiários do bolsa família e desempenho dos serviços básicos de saúde* [relatório final]. Pelotas: Universidade Federal de Pelotas; 2013.
34. Santos LMP, Guanais F, Porto DL, Morais Neto OL, Stevens A, Escalante JJC, Oliveira LB, Modesto L. Peso ao nascer entre crianças de famílias de baixa renda beneficiárias e não beneficiárias do Programa Bolsa Família da Região Nordeste (Brasil): pareamento entre CadÚnico e Sinasc. In: Brasil. Ministério da Saúde (MS). *Saúde Brasil 2010: uma análise da situação de saúde e de evidências selecionadas de impacto de ações de vigilância em saúde*. Brasília: MS; 2007. p. 271-293.
35. Paes-Sousa R, Santos LMP, Miazaki ES. Effects of a conditional cash transfer programme on child nutrition in Brazil. *Bull World Health Organ* 2011; 89(7):496-503.
36. Jaime PC, Vaz ACN, Nilson EAF, Fonseca JCG, Guadagnin SG, Silva AS, Sousa MF, Santos LMP. Desnutrição em crianças de até cinco anos beneficiárias do Programa Bolsa Família: análise transversal e painel longitudinal de 2008 a 2012. In: Brasil. Ministério do Desenvolvimento Social e Combate à Fome (MDS). *Cadernos de Estudos desenvolvimento social em debate,* n.17. Brasília: MDS; 2014. p. 49-63.
37. Malta DC, Andrade SC, Claro RM, Bernal RTI, Monteiro CA. Evolução anual da prevalência de excesso de peso e obesidade em adultos nas capitais dos 26 estados brasileiros e no Distrito Federal entre 2006 e 2012. *Rev Bras Epidemiol* 2014; 17(Supl. 1):267-276.
38. Brasil. Ministério do Desenvolvimento Social e Combate à Fome (MDS). *Marco de Referência de Educação Alimentar e Nutricional para as Políticas Públicas*. Brasília: MDS; 2012.
39. Brasil. Ministério da Saúde (MS). *Dez passos para uma alimentação saudável: guia alimentar para crianças menores de dois anos: um guia para o profissional da saúde na atenção básica*. Brasília: MS; 2013.
40. Monteiro CA, Cannon G, Moubarac J, Martins APB, Martins CA, Garzillo J, Canella DS, Baraldi LG, Barciotte M, Louzada ML, Levy RB, Claro RM, Jaime PC. Dietary guidelines to nourish humanity and the planet in the twenty-first century. A blueprint from Brazil. *Public Health Nutr* 2015; 18(13):2311-2322.
41. Oliveira MS, Silva-Amparo L. Food-based dietary guidelines: a comparative analysis between the Dietary Guidelines for the Brazilian Population 2006 and 2014. *Public Health Nutr* 2018; 21(1):210-217.
42. FAO, IFAD and WFP. *The State of Food Insecurity in the World 2014. Strengthening the enabling environment for food security and nutrition*. Rome: FAO; 2014.
43. Food and Agriculture Organization (FAO). *O Estado da Segurança Alimentar e Nutricional no Brasil: um retrato multidimensional. Relatório 2014*. Brasília: FAO; 2014.
44. Hawkes C, Brazil BG, Castro IRR, Jaime PC. How to engage across sectors: lessons from agriculture and nutrition in the Brazilian School Feeding Program. *Rev Saude Publica* 2016; 50:47.
45. International Food Policy Research Institute (IFPRI). *Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition by 2030*. Washington: IFPRI; 2016.

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