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Between intentions and contingencies, old programs and demands for new nutritional care practices in the Brazilian Unified National Health System

Entre intenções e contingências, antigos programas e demandas por novas práticas de atenção nutricional no Sistema Único de Saúde

Entre intenciones y contingencias, viejos programasy demandas de nuevas prácticas de atención nutricional en el Sistema Único de Salud brasileño

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The analysis by Santos et al. [1] and collaborators was based on the productions of the technical area of the Brazilian National Food and Nutrition Policy (PNAN) within the scope of the Brazilian Ministry of Health. We opted to dialogue with its production from some less explored aspects, which we believe to be necessary for the developing of a broad analysis that allows a comprehensive look at the complexity of the implementation of this policy.

First, we must consider that the achievements and non-achievements of General-Coordination of Food and Nutrition Policy/General-Coordination of Food and Nutrition (CGPAN/CGAN) were conditioned by the political and institutional contexts of the different governments in this trajectory and that involved the necessary defense of their institutional sustainability, present both in the formation of the agenda and the processes of formulation and updating of PNAN, and in the priority strategies implemented [2]. Despite pointing out some elements in this sense, our analysis has limitations related to the association of the implementation of the PNAN with the general context of the Brazilian Unified National Health System (SUS), such as regarding its underfunding, interfederative conflicts over responsibilities to guarantee the right to health, disputes over care models, among others.

Exploring these aspects would help understand why, in the authors' analysis, CGAN's actions for the implementation of the guideline for the organization of nutritional care, present in the second version of the PNAN, were considered equivalent to those for the implementation of the guideline for prevention and control of nutritional problems of the first version of the policy, although the guidelines present significant differences in their intentions and recommendations on practices in the SUS.

In the PNAN updating process, CGAN needed to establish its role on the policy and system of food and nutritional security (FNS), in addition to the continuous defense of its place in the Brazilian Ministry of Health, in a moment in which the guidelines for the organization of Health Care Networks (HCN) and the updating of the Brazilian National Policy of Primary Care (PNAB) guided the management. In this scenario, the new PNAN reaffirmed its intersectoral commitment and strengthened its intrasectoral role [2]. Thus, its first guideline points to ways for the organization of nutritional care in the SUS, detailed in the following guidelines, and the latest guideline addresses articulation and cooperation for FNS [3].

The first guideline deals with the organization and provision of care related to food and nutrition in the HCN, and, although it emphasizes practices in the scope of primary health care (PHC), as the ordinator of the networks and coordinator of care, recognizes that such organization is also neces-

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sary for the context of specialized outpatient and hospital care, indicating, among other issues: its cross-cutting nature regarding other specific policies; the need to develop protocols and technical standards, including the standardization of criteria to promote equity and regulation of access to food for special purposes; the interaction of clinical and nutritional follow-up with meal production and nutritional therapy services in hospitals [3].

Another important difference between the two versions was the recognizing of care for people with special dietary needs as a demand for nutritional care in the SUS, due to the demands of organized groups working in spaces of social participation [4]. This recognition may contribute to expands the offers of nutritional care in the SUS to other audiences, in addition to those that are generally prioritized by epidemiological criteria.

For some years, the Brazilian Ministry of Health induction for the organization of the thematic HCN expanded the offer of specialized care in the municipalities by the creation of services such as psychosocial care centers, therapeutic residences, rehabilitation centers, emergency care units and even of hospital beds for specific conditions. Besides promoting strategies for the expansion and qualification of PHC services, aiming at their greater resolution considering the increasing diversity and intensity of the population's health demands [5].

However, according to the sources explored by Santos et al. [1], CGAN had no actions to induce and/or support the organization and qualification of nutritional care in specialized care services. Although the guidelines for organizing a line of care for people with obesity include recommendations for these services, they only updated the qualification criteria for hospitals that perform bariatric surgery. Despite recognizing the latent problem of judicialization to ensure access to nutritional formulas, these guidelines' actions on this subject were on the sidelines of the priority agenda.

We understand that the Brazilian Ministry of Health technical and financial support for nutritional care in specialized care could offer managers and professionals parameters for planning the provision and qualification of care, and optimization of resources. The adoption of official protocols of the SUS, for example, could prevent conflicts of interest in the prescription, purchase and dispensing of nutritional formulas, since this process may be based on the recommendations of the manufacturers of these supplies or the scientific associations financed by them in the absence of a protocol.

In the scope of specialized care, we must remember that the Brazilian Ministry of Health has no specific direction or support for food/meal production units in health services, which are guided only by the technical regulations of good practices and their own standards, when existing. Besides its direct contribution to the recovery and maintenance of the health of people and workers, public purchases of food for SUS services could contribute to healthy and sustainable local food systems.

For hospitalized individuals, feeding may be the only link with their previous life outside this environment, being more than a nutrient vehicle. The PNAN principle that recognizes food as an element of humanization of health practices corroborates studies that claim a more flexible and humanistic practice of hospital feeding, which explores its symbolic and sensorial aspects [3,6,7].

Regarding PHC, the teams are working amidst a complex health situation for individuals, families and communities, which requires the innovation of nutritional care practices that go beyond those promoted by CGAN. The creation of the Family Health Support Centers (NASF, in Portuguese) contributed in this sense, allowing the creation of strategies that strain the classical practices of so-called nutrition in public health and include the experimentation of nutritional care from an expanded and shared clinic, as well as the resignifications of food and nutritional education in dialogue with the needs of each territory [8,9].

The institutional locus of CGAN in the Brazilian Ministry of Health imposes barriers to expand its mechanisms for inducing practices for the entire HCN. At the same time, the perpetuation of some programs seems to contribute to their institutional stability, which may allow their investments in supporting emerging local practices in response to the new demands of nutritional care in the SUS [2].

These demands are constituted by the need to respond to the health-disease situation of the Brazilian population through health care practices consistent with the principles of universality, integrality and equity. Thus, an important note in the path of analysis on the implementation of the PNAN, is that, besides evaluating the implementation of its guidelines. It is needed to investigate the coherence between the practices developed and the principles of this policy, which support its dialogue with the FNS and the humanization of the SUS [3].

Contributors

K. P. S. Alves and C. C. S. Santos conceived and written the article. J. B. Lignani and R. M. Albuquerque contributed to conceive the article, the critical review and approval of the final version.

Additional informations

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