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Access to food in a health unit territory: a multidimensional approach

Acesso aos alimentos no território de uma unidade de saúde: um enfoque multidimensional

Dafne Pavão Schattschneider[1]
Eliziane Nicolodi Francescato Ruiz[2]
Marianela Zúñiga Escobar[3]

[1] Universidade Federal de Ciências da Saúde de Porto Alegre, Complexo Hospitalar Santa Casa de Porto Alegre. Porto Alegre, RS, Brasil.

[2] Universidade Federal do Rio Grande do Sul, Departamento de Nutrição. Porto Alegre, RS, Brasil.

[3] Universidade Federal do Rio Grande do Sul, Programa de Pós-graduação em Desenvolvimento Rural. Porto Alegre, RS, Brasil.

Correspondence
Dafne Pavão Schattschneider
E-mail: dafneps7@gmail.com

Abstract

Food and Nutrition Security (FNS) is translated not only into the eradication of hunger, however, in also guaranteeing a dignified access to adequate and healthy food. This study aimed to analyze access to food with a multidimensional approach, in a territory of a Health Unit of the city of Porto Alegre, state of Rio Grande do Sul, Brazil. The research approach was qualitative; semi-structured interviews were used as a technique for the collection of empirical data among users of the health unit and among a focal group with professionals of the health team. The discursive content was examined through the thematic analysis, based on the concept of Access used in the field of Collective Health, consisting of four dimensions: economic, technical, political and symbolic access. It was observed that the interviewees build their own strategies in the search to achieve all the dimensions of access to food, with food being a priority in daily family planning. However, there is no guarantee of regular and dignified access to adequate and healthy food. In order to achieve this, it is necessary, in addition to individual strategies, a greater integration of Health with other sectors, in the proposal of public policies that, together with the Bolsa Família Program, may improve the situation of FNS and the Human Right to Adequate Food.

Keywords: Food and nutrition security. Healthy eating. Health services.

Resumo

A Segurança Alimentar e Nutricional (SAN) se traduz não apenas na erradicação da fome, mas também na garantia do acesso, de maneira digna, a uma alimentação adequada e saudável. O objetivo deste estudo foi analisar o acesso aos alimentos com um enfoque multidimensional, em um território de uma Unidade de Saúde de Porto Alegre-RS. A abordagem da pesquisa foi qualitativa; utilizaram-se entrevistas semiestruturadas como técnica para a apreensão dos dados empíricos junto a usuárias da unidade de saúde e um grupo focal com profissionais da equipe de saúde. O conteúdo discursivo foi examinado através da análise temática, a partir do conceito de Acesso utilizado no campo da Saúde Coletiva, constituído em quatro dimensões: acesso econômico, técnico, político e simbólico. Apreendeu-se que as entrevistadas constroem estratégias próprias na busca por realizar todas as dimensões do acesso aos alimentos, sendo a alimentação uma prioridade no planejamento familiar cotidiano. Não há, porém, garantias de um acesso regular e de maneira digna a uma alimentação adequada e saudável. Para isso se faz necessário, além das estratégias individuais, maior integração da Saúde com outros setores, na proposição de políticas públicas que, juntamente com o Programa Bolsa Família, possam melhorar a situação da SAN e do Direito Humano à Alimentação Adequada.

Palavras-chave: Segurança alimentar e nutricional. Alimentação saudável. Serviços de saúde.

Introduction

Food and nutrition are basic requirements for the promotion and protection of health.[1] Brazilian actions and policies focused on the food and nutrition issue have been structured up to the point where mechanisms could be inserted allowing the human right to adequate food to be made effective. An important milestone was the Fome Zero Project (Zero Hunger Project), in 2003,[2] which places this issue as a priority in the governmental agenda. Then, a greater space for discussion and institutionalization occurred with the creation of Law no. 11.346/2006, Organic Law of Food and Nutrition Security, which in its article 3, in conceptualizing Food and Nutrition Security (FNS), signals, among other factors, the attainment of the right of all to regular and permanent access to quality food,[3] and finally, the Human Right to Adequate Food (HRAF) was ensured among the social rights of the Federal Constitution, with the approval of the Constitutional Amendment no. 64/2010.

Assuming that FNS does not only mean the eradication of hunger, but also the guarantee of a universal access, in a dignified way, to an adequate and healthy diet, it is necessary to extend the scope of the actions of the different sectors involved in the promotion of FNS, among them the Health sector. The expanded conception of FNS, capable of targeting more integral actions in food and nutrition, translates very well into the definition presented by the Conselho Nacional de Segurança Alimentar e Nutricional (National Council on Food and Nutrition Security), in its discussion at the Third Conference of FNS, which is:

> A realização de um direito humano básico, com a garantia ao acesso permanente e regular, de forma socialmente justa, a uma prática alimentar adequada aos aspectos biológicos e sociais dos indivíduos, de acordo com o ciclo de vida e as necessidades alimentares especiais, pautada no referencial tradicional local. Deve atender aos princípios da variedade, equilíbrio, moderação, prazer (sabor), às dimensões de gênero e etnia, e às formas de produção ambientalmente sustentáveis, livre de contaminantes físicos, químicos, biológicos e de organismos geneticamente modificados.[4(p31)]

The conception of this research was based on the importance that access to food assumes in the guarantee of FNS, as well as the necessary extent, not only theoretical but also operative, of the theme. The objective was to analyze how the access to food happens, having as focus a territory attached to a Health Unit of Porto Alegre, which is inserted in the periphery of this capital and presents a peculiarity: it is distant from several food commercialization establishments, as well as from the networks of supermarkets and food marketplaces, it has a greater socioeconomic vulnerability and rugged topography that makes it difficult for people to move to produce and access food.

In order to operationalize the analysis on access to food, proposals from the field of Collective Health on the concept of access to health,[5] are interesting. This discussion addresses four dimensions that would compose access: economic, technical, political and symbolic. Applying the proposal of access to health for access to adequate and healthy food, it is possible to maintain the same dimensions, with small adaptations to the object of study in this research. The economic dimension is characterized by the ability of individuals to acquire, through their purchasing/production power, sufficient food, of adequate nutritional quality, with cultural acceptability and obtained in a socially acceptable manner. The technical dimension comprises a universal, equitable and integral distribution of the FNS services/equipment, which enable individuals to adequately consume healthy food. The political dimension concerns the recognition, by individuals, of adequate food as a human right, as well as the attainment of agricultural, environmental, economic, social and welfare policies and of political-economic systems that recognize and establish FNS as a human right. The symbolic dimension, on the other hand, involves the perceptions and conceptions of the subjects, as well as their social representations about food.

Thus, access to food studied from a multidimensional approach seeks to contribute to the systemic perspective of FNS, in which problems are perceived in an interconnected and interdependent manner as they exist in nature, and not solved in isolation.[6]

Methodology

Given the nature of the object, the study was guided by the qualitative approach. Assuming that the notion of access is also a social construction, the analyses demand more comprehensive positions of reality. In this context, we sought to apprehend the search for the meaning of phenomena in the space of intersubjectivity present in the informants' experience.

The population under study consisted of two parts: the users of the studied health unit (HU) and the members of the health team (HT). For the selection of users, residents of the HU territory, the study was based on the assumptions of the qualitative tradition, in which statistical representativeness of the sample is not relevant.[7] Thus, the sample was dimensioned with the objective of reaching a certain diversity and, mainly, the theoretical saturation.[8]

The choice of female users was due to the fact that women are the main responsible or protagonists of the food choices of their families. In addition, in the search for informants who could illustrate differences in FNS policies, such as the Bolsa Família Program (BFP, a social welfare program), we chose to select only women, considering that they are the holders of the BFP. The interviews were carried out in the households of the interviewed women, considering that this place composes a more favorable environment for this purpose. For the interviews, there was the monitoring of community health agents (CHA); from them, the interviewees were also selected, following the criterion of electing residents of the different micro areas of the HU territory responsible for each of the CHA.

As a technique for the collection of empirical data among users, interviews were conducted composed of semi-structured guiding questions that covered the four dimensions of access to food. We observed that the adequacy of the sample, using the saturation criterion, was reached from the eighth interview. For the description of the results, the users are identified from "u1" to "u8". With the HT, the focal group technique was used.[9] The focal group consisted of 15 professionals, including: a physician (p1), a nurse (n1), two nursing technicians (n2 and n3), a dentist (d1), an oral health technician (d2), a CHA (a1) and eight residents (r1 to r8).

In order to evaluate the data, the Content Analysis of the thematic type was carried out, proposed by Minayo.[10] Operationally, the author divides it into three stages: pre-analysis, material exploration and treatment of obtained results and interpretation. From this, the interviews and the focal group were transcribed and processed; then the empirical material was subjected to transverse reading, in order to allow the impregnation by the sense of the "whole" of each statement. For

the organization and identification of the themes that comprised the four dimensions of access to food, present in the narratives, the Nvivoll® software was used.

Following the recommendations of Resolution no. 466/2012, the research was submitted and approved by the Research Ethics Committees of the Universidade Federal do Rio Grande do Sul (Federal University of Rio Grande do Sul) and the Secretaria Municipal de Saúde (Municipal Health Department) of Porto Alegre.

According to the Informed Consent Term used in this study, the researchers were committed to maintain secrecy about the individual information obtained, including the location of the territory under study.

Results and Discussion

The analysis process was organized in four central axes, i.e., dimensions of access: economic, political, technical and symbolic. Then, the themes that emerged from the generated data were described for each axis.

Economic Dimension

In the analysis of this dimension, some interviewees speak of the difficulty in administering family income, which is almost totally used for food: "*It's not easy, we work only to eat, one piece of clothing, only once a year*" (u1). From this speech, it was possible to perceive the non-attainment of the full right to regular and permanent access to adequate and healthy food, in sufficient quantity, since, to ensure access to food, other essential needs, for some of the interviewees, seem to be impaired. In other words, one has to make choices between ensuring food or other needs.

From the difficulties in relation to family income, it was observed that there are processes of organization of the purchases that are adjusted to the period in which they have some money and when they receive the salary (or its portions). Thus, according to the possibilities of income, the purchase of food follows a periodicity that may be daily, weekly or even monthly.

A relevant aspect that emerged in the interviewees' reports was that buying and food choices follow a logic that includes the lowest prices. Hence, the interviewees adapt the menu to the preferences of the family and their ability to create and adapt dishes with cheaper ingredients.

> *Oh sure, I search for the lowest price (u8).*
>
> *I always try to adjust and not waste, because everything is very expensive. I buy a lot of stew because it's the easiest to administer inside a house, my husband hates it, but then I make meatballs, pancakes, steak [...] I'd like to be able to buy prime beef, these things, but I can't (u5).*

The HT also stressed that the search for the lowest price is the main factor for the food choices of the residents of the territory, mainly because *money doesn't buy the same things as it did before* (d2). Something important to highlight is that the *cesta básica* (a set composed of 13 basic items to feed an adult worker for one month) with the highest cost of the set of foodstuffs in December 2017 was the one from Porto Alegre (R$ 426.79). The minimum wage estimated as necessary to maintain the basic needs of a family of four people should be equivalent, also in 2017, to R$ 3,585.05 or 3.86 times the minimum wage which was R$ 937.00.[11] This shows the difficulty in managing family income in purchasing food for low-income families.[12]

Although the search for the lowest price is one of the main elements that guide the purchase of foods, it was possible to perceive that more expensive ones may also be part of the family's diet. However, foods with higher prices are an exception in everyday life, as some interviewees show:

> *What we really like, a lasagna for example, my girls love it, but it's hard for me to make it because it's expensive, so I only make it when there's some extra money (u3).*

> *Barbecue is also hard, right?, but we have it when we can, and the meat is expensive (u7).*

The difficulties of economically accessing foods, especially those considered healthy by the HT, are perceived by professionals as an important challenge that exists when working in the field of health, as the following statement illustrates:

> *To learn how we can advise patients when they tell us: but doctor I don't have money (d1).*

Corroborating patients' complaints to professionals, Borges et al.[13] argue that for Brazilians with lower purchasing power to achieve an adequate diet, it is necessary to spend more on food than they usually do and are able to invest. Thus, it is possible to observe that in order to promote healthy food practices in the health sector, processes of permanent education of the teams become important to approach such theme and of food education with the users for them to make better choices within the economic possibilities, in addition to actions that are intersectoral and concern policies of income distribution and broader actions directed to the environment in which they live and to the food system as a whole.[14]

Claro & Monteiro,[15] when analyzing family income, food prices and the purchase of fruits and vegetables, indicate that the increase in the income of families, especially the poorest ones, as well as the reduction of the price of fruits and vegetables, both for the support to the chain of food production and the fiscal measures, would be effective ways to increase the participation of these foods in the diet of Brazilian families. It is an important factor for these families to achieve an adequate and healthy diet.

Technical Dimension

The territory attached to the studied HU is located at the top of a hill and, therefore, as reported by the research participants, there are transportation and movement difficulties. However, there is a truck that goes into the territory to sell fruits and vegetables, people who sell *cestas básicas* door-to-door, a butcher shop and a number of small markets, which have a limited variety of products, mostly ultra-processed foods. There are also some slightly larger markets, which, in addition to the mentioned products, sell some meats, fruits and vegetables, however, still with an extensive supply of ultra-processed products.

Because there are several food marketing places, the idea of a food desert does not apply to this reality, a term that has been used to describe the absence of places that sell food in a defined area and that may indicate a barrier to the purchase of certain food items.[16] On the other hand, it is also not possible to describe it with a considerable diversity of establishments, given the low variety of food options and the absence of marketplaces, restaurants, bakeries, as well as sufficient public transport to move with greater ease to more distant places. Therefore, the technical dimension of access does not appear to be widespread in the area.

According to the discussion by Jaime et al.,[17] the areas with greater socioeconomic power are those with higher number of public transport connections, parks and public sports facilities, which also present higher densities of all types of food supply establishments, especially those that supply fruits and vegetables, providing greater access and consumption to these foods, as well as better health parameters for the residents of the region, a reality not found in the territory under study.

Duran et al.,[18] when analyzing the stocks of establishments that market food in Brazil, indicate that the best-selling products in low-income neighborhoods are processed foods and soft drinks. Similarly, the small markets of the studied HU territory also present this characteristic. In these markets, the interviewees buy what is immediately needed (on a daily basis) to prepare a meal, however, they also buy processed foods and sweets, whose consumption is not planned or necessary to meet the basic needs of the family.

> *What I buy more at the bar near by is bread, milk, juice, soda, it's more on Saturdays and Sundays the soda. (u7).*
>
> *Only sometimes here at the bar if I need to, like, a tomato, an onion, very fast, when there's none in the fridge. (u2).*

Based on the interviewees' statements, although these small markets do not have all their food needs, physical access to them is facilitated and considered important. It also appears in the speech of the HT that in the territory there are several elderly people with difficulty of locomotion, for which members of their families are responsible for bringing them food. Thus, access to these establishments is becoming a form of autonomy for these residents, as one interviewee reports:

> *I buy bread here, in the market down there, I go in the morning to get some bread. Oranges, these things are sometimes there, so I buy them. But I won't go far. (u6).*

The same way as small markets, the other establishments in the territory are, when compared with the more distant supermarkets, little used by the interviewees. However, there is reference to the use in the territory of the delivery of *cestas básicas* sold door-to-door by third parties, especially as they consider as a facilitator receiving food at home and the possibility of paying by monthly installments.

Regarding purchases of basic and main foods for the family, the interviewees report that they buy them predominantly in places outside the territory, such as supermarkets. Although they prefer to make their purchases in places near their homes, the search for foods outside the territory is due to the values that were previously given by them. The values and meanings attributed to food from the establishment of purchase, as well as the relationships that involve them, are important factors for consumer interest.[19] The values given to supermarkets, according to the interviewees' perspectives, were the price, the quality and the variety of products marketed in these places:

> *It's a little further, but it's worth it, you choose what you want, in these markets here you can't buy. (u3).*

> *It's sad that there's nothing here, it's so poor our neighborhood, it has no market [bigger], it doesn't... I'm sure it's also much more expensive. (u8).*

In addition to the already described values attributed to supermarkets, another important value that qualifies some of the frequented markets is the possibility of delivering food at home with a car provided by the establishment, being charged a small additional fee for transportation. This creates a certain fidelity of the interviewees to the establishments, which added to the fact of always attending the same establishment, creates a bond with them:

> *I buy most of the things there, my partner, from my salary, he's practical, right? [...], there's a lot of good stuff there. (u8).*

According to the HT, the territory has "*a fertile land for planting*" (r1) which is little explored by the residents. Corroborating the observation of the HT, we verified that only two interviewees have a vegetable garden at home. Despite some obstacles in the region, such as the fact that the territory is on a hillside with stones, the cultivation of vegetable gardens could be explored by the HT with a technology of fundamental importance for the approximation between professionals and users, the exercise of autonomy and of self-care and, consequently, for the promotion of FNS and health, as advocated by the current National Food and Nutrition Policy.[1]

In the speeches, it was possible to perceive, as a strategy for the consumption of fruits and vegetables, the purchase of these foods at prices below the usual in improvised greengrocers on the floor of some corners, in front of bus stops and at commercial establishments in the city center. Thus, the sale of fruits and vegetables has been growing in Porto Alegre, as well as their purchase. These places are considered by the interviewees as having easy physical and financial access, however, little is known about their origin and sanitary quality, i.e., how they are produced, stored and distributed.

In addition to family production, marketplaces are important options for access to fresh and minimally processed foods, which are recognized as markers of a healthy diet based on fruits and vegetables.[20] However, food purchases at marketplaces are not usual among the interviewees. The scant reports of the purchase of food in these places called our attention, as well as the lack of statements about the search for the consumption of organic food, considered free of pesticides.

One factor to be considered is that there are no marketplaces on the territory, and to access them, more trips are necessary, which in turn is more difficult than going to other establishments such as supermarkets, even being outside of the territory, which is where they buy all food consumed by the families. It is important to emphasize that the presence of establishments that market adequate and healthy food in the territory is relevant to increase the consumption of these foods,[17] however, it is not the only factor interfering with their purchase. We observed that, regardless of the distance, the search for cheaper and higher-quality foods, according to their perceptions of quality, is even more important for the interviewed ones, even if they need to go further.

Political dimension

In this dimension we highlight the Bolsa Família Program (BFP) as the main guarantee policy for the FNS and the HRAF, as the program most accessed by the population of the territory. In the reports, it was possible to perceive the fundamental role that the BFP has in the income of the families, being, for one of them, the main source. Consequently, it is perceived that their access is fundamental for increasing the quantity in the purchase of food, however, it does not necessarily contribute to the improvement of the quality of the diet. This is one of the main highlights of Cotta & Machado,[21] in a publication that critically reviews the literature and discusses the Bolsa Família Program in the FNS guarantee in Brazil.

The administration of this income from the BFP, even playing an expressive role for other household expenditures, has, on a daily basis, a specific destination that is primarily for food. However, regarding the statements, there is no understanding of how this income should be used, as the speech illustrates:

> *I get R$170.00, it helps me a lot, I use it for the home, whatever I need in the house, if I need the money for some bills as well, it goes where it has to go, what's the next thing is where it goes [...] so when I needed to get a haircut I've used it, because there's nowhere to get it from, but it's the kind of thing I keep thinking "can I or can't I?", because after all I don't know if this is the case or if it isn't. (u5).*

Although the BFP is a right of the Brazilian citizen, this understanding was not present in the interviewees' speech, nor the recognition that it is a policy that is moving towards the guarantee of the HRAF. In this aspect, doubts were also expressed about who should or should not have access to the BFP, in addition to the information available on its use by the beneficiaries, which seems to have a direct impact on their claim.

> *[Interviewer] And do you have any kind of benefit, like bolsa família?*
>
> *[Interviewee] No, because my mother says she never wanted it because she doesn't need it, because then you take it away from those who need it. (u7).*
>
> *I get the bolsa família, I don't even know how I got it, I signed up to do the social security card, then I got the card, they said I could use it, so I do. (u5)*

Starting from the discussion with the HT, it was remarkable the non-recognition of the BFP as a tool to guarantee FNS. We observed the lack of full knowledge of the functioning of the BFP, its connection with FNS, as well as the potential for achieving, in addition to conditionalities, interfaces with SUS and other sectors, such as schools. From this, it was exposed, by the HT, the importance of a better understanding of the concept of an adequate and healthy diet, from the FNS perspective, as one of the ways to promote health in team practices.

There was a reflection in the focal group on the main barriers to working with broader health perspectives. The professionals discussed the centrality of the disease, the technique and the programmatic actions at work, both in the supply and in the demand of services by the users. Therefore, the HT states that:

> *The priorities are given, we end up with hands tied in the issue of promotion as a whole, not only the food issue [...] we have a short sheet, we pull a little on one side and uncover the other side. (p1).*

Welfare logic, with a central axis in treatment, is historical in Brazil and it has been discussed in the literature. Cecílio[22] states that the welfare logic ends up "colonizing" the life of the unit and "compressing" the activities of disease prevention and health promotion, since there is a "dispute" for the use of resources in the service.

The potential of the BFP is conditioned to the capacity of public management and of civil society to regulate the fulfillment of its objectives, including the promotion of FNS.[21,23] Thus, the search for guaranteeing access to food by the political dimension is directly related to understanding the complexity of FNS and of the BFP, of the role of the State and of the citizen, in the control and monitoring of compliance with public policies.

In the interviews, it was also possible to observe few reports on the construction of aid networks between neighbors and family, and there is no evidence of the formation of a more solid and integrated social fabric in the territory that is capable of strengthening the potential of the micropolitics of daily life. It seems that what is most present is individualism, when referring to *my food* and *my purchase*, without mentioning actions of exchange and support among the residents, except for some family relationships:

> *Usually there's no one for whom I can do this, but every once in a while, but it's very rare, if I need something that I don't have here I ask my sister, she lives up there and then my son goes there and gets it. And she asks for more than I do, she's less organized. (u2).*

Regarding the fact that it would be up to each one individually to face the adversities of daily life, one realizes a certain rejection in exchanging and helping other people. There is not a perception of these relations as support and reciprocity, however, as a disorganization on the part of those who may ask for help. Therefore, it is considered important by the interviewees that each individual, on their own, has autonomy for their purchases and activities without needing others: "I don't ask anything for anyone" (u6).

Evidence indicates that when a social network is strong and integrated, it is able to emphasize positive aspects of social relations, such as mutual help, sharing besides food, but also information, the aid in moments of crisis.[24]

Social relations, mediated by food, could be an important tool in building a support network. This network would be able to strengthen not only the access to a healthy diet to achieve a better FNS situation, but also social belonging and belonging to a health territory, consequently strengthening the exercise of a more solidary and active citizenship in the search for rights for the territory.[24]

Symbolic Dimension

From the transcription of the interviewees' speeches, we produced a "word cloud" (figure 1), i.e., a digital diagram that shows the frequency level of words in the text. The more the word is used, the more prominent and the bigger is the size of this word in the diagram. In this sense, the terms

that stood out most when we questioned the interviewees about the main meals were *rice*, *beans*, *meat* and *salad* (figure1). It was also representative that, together with food, words such as *usually*, *generally* and *eats* were highlighted, which denote that the consumption of these foods is frequent.

Figure 1. Word cloud prepared based on Nvivo®, on the most consumed foods in main meals. Porto Alegre, June 2017.

Source: elaborated by the author.

One of the elements that most stood out in the speeches refers to the symbology that the presence of meat in the meals has for the interviewees (figure 1):

> *[Interviewer] Don't you have any meatless meals?*
>
> *[Interviewee] No, I'm not going to the fire." (u1)*

Even with its high cost, meat is highly valued. In a population-based study, Schneider et al.[25] analyzed meat consumption among residents of Pelotas-RS and observed that there is a significant consumption of this food, being frequent by all interviewees, and daily for some. People with the

lowest economic level stand out, presenting consumption, in the category daily consumption of red meats, of 60% more than the others.

It is also when purchasing meat that they seek more places with *better quality*, as reported by one of the interviewees:

> *The meat there is good, I like that meat, not any meat (u6).*

Meat also seems to determine the place where the other food items will be purchased.

Salad, although it is highlighted (figure 1) and its consumption is considered important, is not diverse and does not have a central space in the meals like rice, beans and meat. From the understanding of the HT, this fact could possibly be due to the expense for its acquisition, the time spent to prepare it and because it is not part of the dietary habits of this population, or even by the lower capacity of satiety coming from its consumption in comparison to other foods. Another aspect raised about *salad* was the little appreciation of its consumption, which appeared when one interviewee said that she consumes only tomato, lettuce and cabbage, these being "*the salad of the poor*" (u1).

The consumption of processed foods also emerged in the research, however, with more intensity in the HT report. For the professionals of the HU, the consumption of processed foods occurs because of different reasons, such as the ease of consumption, being necessary only to open the packaging; the status related to this practice, especially among children in the school environment; as well as the technical access facilitated in the territory under study, mainly by the commercialization available in the small markets.

In contrast to the consumption of processed foods, it is also possible to observe the prominence of the terms *I make/to make* in figure 1, denoting that the practice of preparing meals based on rice, beans and meat is present. The concern about the preparation and choice of food appears mainly when it involves the care of children and of the elderly, then there is recognition of the preparation of food, with the tradition and variety that culture and income allow, in order to take care of the family health.

Even though the consumption of rice and beans is noticeable (figure 1), there is a devaluation of this habit by the users and by the HT. Some interviewees consider rice and beans, as well as lettuce, tomato and cabbage, as *food of the poor*, and not as a Brazilian tradition that should be appreciated:

> *Rice and beans are also all the time, we are very used to eating rice and beans, it's the food of the poor. (u7).*

On the other hand, in the understanding of the HT, rice and beans enter the routine of users, characterizing as an automatic practice, "*it's what they know how to prepare*" (n1), and monotonous. Therefore, these foods do not assume a positive connotation for the HT, i.e., they are not recognized as healthy at a time when, according to the POF,[26] and discussed by Souza et al.[27], the diet of Brazilians has been characterized by the introduction of high-energy processed foods and sugar-sweetened beverages. A traditional diet based on rice and beans, in addition to being important to preserve national culture and strengthen the practice of meal preparation, plays a respectable role as a protector against overweight and obesity, unlike diet patterns rich in fats, sweets and processed foods.[28-30]

For the HT, foods that would deserve greater insertion in the users' diet, and therefore to have a better use by the team, are, along with vegetables, whole products, as well as yogurt, cheese, meat, tuna and wine, among alcoholic beverages. In other words, foods that are not part of the food and cultural repertoire of most part of this population, more expensive, however, exalted, even by science, as prototypes of what is healthy. Thus, it is possible to perceive the tendency of health practices to medicalize everyday eating.[31]

Evidence indicates the importance of food and nutrition policies that involve not only the stimulus of consuming healthy foods, such as fruits, vegetables and whole grains, but also maintaining the consumption of traditional basic foods, such as rice and beans,[27] the latter two presenting an easier economic access for the families with lower purchasing power.

Conclusions

The purpose of this study was to analyze the dimensions of the "access" category proposed by the field of Collective Health, which, applied to the FNS perspective, could help in the comprehensive approach of our study object. Through this referential and the qualitative approach, possibilities were sought to broaden the discussion of access in which, in addition to the economic and technical aspect – i.e., people's ability to have income to purchase food, as well as the price, food supply and displacement to purchase them - other elements must be considered. Among them, it is also necessary to consider the political dimension imbricated in the possibilities of access of the users, as well as the understanding of the symbolic, also through the values prescribed by the field of health that construct an ideal diet and that are concretized by the orientations of the attention services within the territories.

It was possible to understand that even if there were no full guarantees of regular and dignified access to adequate and healthy food, the interviewees sought strategies for access to food, as this was a priority in daily family planning. However, at the same time, it was possible to perceive some

conformity with the reality lived by each one of them, including the constant search for access to food as a personal and individual duty, without acknowledging the potential of support networks and diet as a human right to be claimed, and the role of the State in promoting and ensuring adequate and healthy food for the population.

It is also essential to add that in order to guarantee a regular and dignified access to adequate and healthy food, dialogue among sectors is necessary, and it is important to have a greater integration of the Health and Primary Care sectors with the other sectors that involve working with FNS, such as the social assistance and agriculture sectors.

Thus, it is important to propose public policies, which together with the BFP may enhance the HRAF and FNS. However, their potentialities are conditioned by the ability of public power and of civil society to regulate the fulfillment of their purposes, including the promotion of FNS, as well as the implementation of more general social and economic policies that integrate the different sectors. Among them, we may highlight policies to reduce prices of foods considered healthier and the application of stricter taxes on foods with lower nutritional quality; policies that encourage the production of local or regional food; better distribution of income, in order to increase the purchasing power of the population, as well as food education policies. All these factors, together, may play an important role in regular and permanent access to quality food.

One should remember that access to food is not an isolated issue; on the contrary, it is a complex and multidimensional theme, which is part of the FNS approach. Therefore, we have focused on axes to facilitate the analysis, however, we understand that in the concreteness, in the daily life of people, the dimensions are intertwined and not separated.

Thus, we may conclude that there is a theoretical-methodological challenge for those who wish to work on the subject of access to food, and that it will be difficult to find answers and design new intervention strategies without the study of local specificities and singularities.

Contributors

Schattschneider DP conceived the research project, worked on the data collection, on the interpretation of results, on the writing and on the revision of the article; Ruiz ENF and Escobar MZ worked on the conception of the research project, on the interpretation of the results, on the writing and on the revision of the article.

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References

1. Brasil. Política Nacional de Alimentação e Nutrição (PNAN). Brasília: Ministério da Saúde; 2012.
2. Brasil. Fome Zero: a experiência brasileira. Brasília: Ministério do Desenvolvimento Agrário; 2010.
3. Brasil. Lei nº 11.346 de 15 de Setembro de 2006. Cria o Sistema Nacional de Segurança Alimentar e Nutricional – SISAN com vistas em assegurar o direito humano à alimentação adequada e dá outras providências. Diário Oficial da União. 18 set. 2006.
4. Brasil. Conselho Nacional de Segurança Alimentar e Nutricional (CONSEA). III Conferência Nacional de Segurança Alimentar e Nutricional - por um desenvolvimento sustentável com soberania e segurança alimentar e nutricional. Relatório final. Fortaleza: Conselho Nacional de Segurança Alimentar e Nutricional; 2007.
5. Jesus WLA, Assis MMA. Revisão sistemática sobre o conceito de acesso nos serviços de saúde: contribuições do planejamento. Cienc Saúde Coletiva. 2010; 15(1):161-170.
6. Maluf RSJ. Segurança alimentar e nutricional. Rio de Janeiro. Petrópolis: Vozes; 2007.
7. Triviños ANS. Introdução à pesquisa em ciências sociais: a pesquisa qualitativa em educação. São Paulo: Atlas; 2012.
8. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. Cad Saúde Pública. 2010; 24(1):17-27.
9. Bomfim LA. Grupos focais: conceitos, procedimentos e reflexões baseadas em experiências com o uso da técnica em pesquisas de saúde. Physis. 2009; 19(3):777-796.
10. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8 ed. São Paulo: Hucitec; Rio de Janeiro: Abrasco; 2004.
11. Departamento Intersetorial de Estatística e Estudos Socioeconômicos. Custo da cesta básica sobe em todas as capitais. São Paulo: DIEESE; 2018.
12. Instituto Brasileiro de Análises Sociais e Econômicas. Repercussões do Programa Bolsa Família na segurança alimentar e nutricional das famílias beneficiadas. Rio de Janeiro: IBASE, FINEP; 2008.
13. Borges CA, Claro RM, Martins APB, Villar BS. Quanto custa para as famílias de baixa renda obterem uma dieta saudável no Brasil? Cad Saúde Pública. 2015; 31(1):137-149.
14. Castro IRR. Desafios e perspectivas para a promoção da alimentação adequada e saudável no Brasil. Cad Saúde Pública. 2015; 44(1):07-09.
15. Claro RFE, Monteiro CA. Renda familiar, preço de alimentos e aquisição domiciliar de frutas e hortaliças no Brasil. Rev Saúde Pública. 2010; 44(6):1014-1020.
16. Beaulac J, Kristjansson E, Cummins AS. Systematic review of food deserts, 1966-2007. Prev Chronic Dis. 2009; 6(3):A105.
17. Jaime PC, Duran AC, Sarti FM, Lock K. Investigating environmental determinants of diet, physical activity, and overweight among adults in São Paulo, Brazil. J Urban Health. 2011; 88(3):567-581.

18. Duran AC, Lock K, Latorre MR, Jaime PC. Evaluating the use of in-store measures in retail food stores and restaurants in Brazil. Rev Saúde Pública. 2015; 49:80.

19. Silva GP, Silva ME, Costa AS, Marafiga EBM, Haas HA. Exposição Feira Agropecuária De Toropi. In: Silva GP, Vendruscolo R, organizadores. Experiências inovadoras em extensão rural na agricultura familiar na região de abrangência do Instituto Federal Farroupilha. São Vicente do Sul: Instituto Federal Farroupilha; 2012. p. 92-99.

20. Oliveira NRF, Jaime PC. O encontro entre o desenvolvimento rural sustentável e a promoção da saúde no Guia Alimentar para a População Brasileira. Saúde Soc. 2016; 25(4):1108-1121.

21. Cotta MRME, Machado JC. Programa Bolsa Família e segurança alimentar e nutricional no Brasil: revisão crítica da literatura. Rev Panam Salud Publica. 2013; 33(1):54-60.

22. Cecílio LCO. Modelos tecno-assistenciais em saúde: da pirâmide ao círculo, uma possibilidade a ser explorada. Cien Saúde Coletiva. 1997; 13(3):469-478.

23. Burlandy L. Transferência condicionada de renda e segurança alimentar e nutricional. Cienc Saúde Coletiva. 2007; 12(6):1441-1451.

24. Andrade GRBE, Vaitsman J. Apoio social e redes: conectando solidariedade e saúde. Cienc Saúde Coletiva. 2002; 7(4):925-934.

25. Schneider BC, Duro SMS, Assunção MCF. Consumo de carnes por adultos do Sul do Brasil: um estudo de base populacional. Cienc Saúde Coletiva. 2014; 19(8):3583-3592.

26. Instituto Brasileiro de Geografia e Estatística. Pesquisa de orçamentos familiares 2008-2009: análise do consumo alimentar pessoal no Brasil. Rio de Janeiro: IBGE; 2011.

27. Souza AM, Pereira RA, Yokoo EM, Levy RB, Sichieri R. Alimentos mais consumidos no Brasil: Inquérito Nacional de Alimentação 2008-2009. Rev Saúde Pública. 2013; 47(1 Supl.):190S-199S

28. Sichieri R. Dietary patterns and their associations with obesity in the Brazilian City of Rio de Janeiro. Obesity Research. 2002; 10(1):42-48.

29. Sichieri R, Castro JFG, Moura AS. Fatores associados ao padrão de consumo alimentar da população brasileira urbana. Cad Saúde Pública. 2003; 19(Sup. 1):S47-S53.

30. Neumann AICP, Martins IS, Marcopito LF, Araujo EAC. Padrões alimentares associados a fatores de risco para doenças cardiovasculares entre residentes de um município brasileiro. Rev Panam Salud Publica. 2007; 22(5):329-339.

31. Prado SD, Kraemer FB, Seixas CM, Freitas RF, organizadores. Alimentação e o consumo de tecnologias. Curitiba: CRV; 2015.

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