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The Human Right to Adequate Food for individuals with cardiovascular diseases: a look at clinical guidelines

O Direito Humano à Alimentação Adequada para indivíduos com doenças cardiovasculares: um olhar sobre as diretrizes clínicas

Abstract

Introduction: Violations of the Human Right to Adequate Food (HRAF) are recurrent, preventing part of the population from having access to a dignified life. Lack of access to this right is linked to food insecurity, a scenario that contributes to the development of cardiovascular diseases (CVDs). Although it impacts clinical care practice, the HRAF is not always addressedin documents in this field. *Objective*: To analyze opportunities for incorporating the HRAF perspective into the Food and Nutrition Care (FNC) approach in documents intended for the care of people with CVDs. *Methods*: A literature review of publications by the Brazilian Society of Cardiology (SBC) from 2015 to 2021 was conducted, using the most recent versions that included a section related to FNC in the document's content, with exclusion criteria being those related to pregnant women, children, and adolescents. The guiding question was: "What opportunities exist for incorporating the HRAF perspective into FNC guidelines for people with CVD in SBC documents?" *Results*: Thirteen documents were selected, of which five were eligible. A biologistic and reductionist approach was identified in the development of FNC actions regarding CVDs, revealing gaps in broadening the perspective regarding the different dimensions of nutrition in the drafting of these documents. The *Dietary Guidelines for the Brazilian Population* was cited by the SBC's fat consumption guideline, facilitating dialogue with the HRAF. The Guidelines on fat consumption and hypertension contained passages related to the HRAF concepts of Adequacy and Acceptability. These emphasized regionality and food culture, as well as principles related to Empowerment and Participation, as they promoted more conscious food choices and government accountability regarding access to information. *Conclusion*: The inclusion of HRAF in Clinical Guidelines is both possible and necessary for expanding food and nutrition care, particularly in the current Brazilian context.

Keywords: Cardiovascular Diseases. Right to Food. Guidelines.

Resumo

Introdução: A violação do Direito Humano à Alimentação Adequada (DHAA) é recorrente, impedindo que parte da população tenha acesso a uma vida digna. A falta de acesso a este direito se relaciona com a Insegurança Alimentar, cenário que contribui para o desenvolvimento de doenças cardiovasculares (DCVs). Apesar de impactar a prática clínica do cuidado, o DHAA nem sempre é abordado em documentos da área. *Objetivo*: Analisar as oportunidades de inclusão da ótica do DHAA na abordagem do Cuidado em Alimentação e Nutrição (CRAN) nos documentos destinados ao cuidado às pessoas com DCVs. *Métodos*: Realizou-se análise documental de publicações da Sociedade Brasileira de Cardiologia (SBC) no período de 2015 a 2021, utilizando versões mais recentes que apresentassem, na composição do documento, parte relacionada ao CRAN, tendo como critérios de exclusão aqueles que fossem relacionados a gestantes, crianças e adolescentes. Foi apresentada como questão orientadora: "quais as oportunidades para inclusão da ótica do DHAA no CRAN destinado às pessoas com DCVs em documentos da SBC?" *Resultados*: Selecionaram-se 13 documentos, dos quais 5 foram elegíveis. Identificou-se uma abordagem biologicista e reducionista ao elaborar ações do CRAN em DCVs, configurando lacunas para ampliação do olhar frente às diferentes dimensões da alimentação, na elaboração destes documentos. O *Guia Alimentar para a População Brasileira* foi citado pela diretriz de consumo de gorduras da SBC, oportunizando diálogos com o DHAA. As Diretrizes sobre consumo de gorduras e de hipertensão arterial apresentaram trechos que se relacionaram aos conceitos de Adequação e Aceitabilidade do DHAA. Estes enfatizaram a regionalidade e cultura alimentar, bem como princípios relacionados ao Apoderamento e Participação, visto que fomentaram escolhas alimentares mais conscientes e a responsabilidade governamental sobre o acesso à informação. *Conclusão*: A presença do DHAA em Diretrizes Clínicas é possível e necessária para a ampliação do cuidado em alimentação e nutrição, principalmente na conjuntura atual brasileira.

Palavras-chave: Doenças Cardiovasculares. Direito à Alimentação. Diretrizes.

INTRODUCTION

Given the contradictions and injustices of a landscape marked by the advance of neoliberalism, the systematic and emphatic reaffirmation of the Human Right to Adequate Food (HRAF) has been a pressing demand. Faced with a hegemonic global system that offers food in quantities never before seen in history, "nearly one billion people do not know if they will be able to feed themselves and their children that day" and over two billion risk themselves consuming foods and beverages associated with premature deaths and preventable diseases.[1]

Although the right to food has been recognized since the last century,[2-4] the rise in Food Insecurity (FI) in Brazil[5] and in various parts of the world[6] indicates that there is still relevance in proposing assertive strategies and in including this debate in different spheres of life, permeating the daily reality of public policies,[7] academic spaces for education and research,[7] and healthcare provision.

Access to quality food to meet individuals' needs is essential, especially in the presence of clinical conditions that require specific nutritional therapy. This aspect must be considered when proposing care strategies, particularly in the current context where the impacts of the health, political, and economic crisis on the Brazilian population's food supply have been recognized.[8]

The rising cost of food, particularly food considered healthier,[9] and persistent income inequality and unequal access to food[10,11] have led to a decrease in the consumption of fresh and minimally processed food and an increase in the consumption of ultra-processed food, especially among the population with higher levels of FI.[7] It is important to note that the higher the consumption of ultra-processed food, the greater the risk of developing cardiometabolic diseases, which include obesity, diabetes, hyperlipidemia, coronary heart disease, stroke, and other cardiovascular diseases.[12] Similarly, it is worth highlighting the relationship between FI and the increased prevalence of cardiovascular diseases (CVDs) and chronic no communicable diseases (CNCDs),[12] as well as a higher risk of death from these diseases.[13,14]

Thus, it is important to promote actions related to food and nutrition care (FNC) which, according to the Brazilian Food and Nutrition Policy (PNAN), include diagnosis, nutritional surveillance, specific dietary guidance, as well as the promotion of adequate and healthy eating and food and nutrition education.[15] Furthermore, it is highly important to establish protocols and therapeutic guidelines related to this care, as these documents are based on "statements systematically developed to assist professionals' decisions regarding appropriate healthcare [...]",[16] thus making them toolsinvolved in advancing and organizing initiatives focused on food and nutrition.[15]

In light of the above, it is evident that identifying strategies that bring together reflections on the HRAF with care for people with cardiovascular diseases is pertinent. Thus, the collection of the Brazilian Society of Cardiology (SBC)[17] was identified as relevant material, since it addresses nutritional care and its relationship with the development, prevention, and health care of these individuals.

Given the various ways in which HRAF, enshrined in the Brazilian Constitution, is denied to the most vulnerable population, its contribution to the development of CVDs, in terms of public health, becomes a cause for concern.

Furthermore, the role of Clinical Guidelines in the care of people with CVDs is fundamental to incorporating strategies for promoting the HRAF. Never the less, it is necessary to emphasize the importance

of public sector engagement to ensure governance grounded in healthier and more sustainable food systems, given the challenges posed by the global syndemic currently being experienced.[6]

In this sense, this article aims to analyze opportunities for incorporating the HRAF perspective into the FNC approach in documents intended for the care of people with CVDs.

METHOD

Document analysis[18] of the SBC's "Guidelines, Position Statements, and Standards," which establish and provide recommendations produced by experts, was conducted. The focus on these documents is based on the understanding that, although they are produced by a medical specialty society, they are written and used by professionals from various fields. Furthermore, it is understood that HRAF must be addressed from an interdisciplinary perspective, extending beyond the scientific field of Food and Nutrition.

The following inclusion criteria were used to search for documents published between 2015 and 2021 on the SBC website[17]: guidelines or position statements published within the mentioned time period, documents containing a section related to FNC, and those addressing the management of conditions such as hypertension, dyslipidemia, atherosclerosis, and acute myocardial infarction (with or without ST-segment elevation) in adults and the older persons as their main topic. When more than one version of the same selected document was identified, the most recent version was chosen. The search was conducted between April and December 2022. As an exclusion criterion, clinical guidelines addressing topics related exclusively to the management of cardiovascular diseases in pregnant women, children, and adolescents, and that did not address FNC, were not considered.

The critical evaluation of these documents, based on a thematic-categorical analysis, was grounded in two fundamental steps: the preliminary analysis and the analysis perse, which relates directly to the study's object, highlighted by the guiding question. The preliminary analysis consists of examining five dimensions of the text: context, author(s), the authenticity and reliability of the text, the nature of the text, key concepts, and the internal logic of the text.[18]

The guiding question of this study was: what opportunities exist for incorporating the perspective of the Human Right to Adequate Food, as expressed in the FNC approach for people with cardiovascular diseases, into SBC documents?

To identify the perspective of the HRAF, we used the summary presented in Table 1, which was compiled from national documents,[7,19] based on the Universal Declaration of Human Rights (UDHR) and General Comment No. 12, which capture the essence and definition of the principles and concepts intrinsic to the HRAF.[2,4]

As an analytical strategy, two steps were followed. In the first, a single author fully read the documents; the second involved highlighting specific sections of interest: (1) introduction and/or presentation; (2) non-pharmacological treatment; and (3) dietary recommendations—according to their availability in each document. In order to identify contextual elements,[18] the sections on conflicts of interest and the authors were reviewed; to examine the text's reliability and authenticity, the references were included in the review. If there was any doubt regarding the selection of sections in the documents, this was evaluated by a second author, and the section was considered for analysis based on consensus between the two authors involved in the selection.

Table 1. Intrinsic concepts and principles for addressing the Human Right to Adequate Food.

Intrinsic Concepts	Description
Availability	Supply in sufficient quantity and quality to meet people's dietary needs, free from harmful substances, and acceptable to a given culture.
Adequacy	Of available foods, from a cultural and nutritional stand point, within hygiene and health standards, free from harmful substances, so that nutritional well-being can be achieved.
Accessibility	Economic: the financial, personal, and family costs associated with acquiring food for a given diet should be such that the satisfaction of other basic needs is not threatened or compromised. Physical: This means that adequate nutrition must be accessible to everyone, including physically vulnerable individuals, such as infants up to six months of age and older children, the older persons, people with physical disabilities, the terminally ill, and those with chronic medical conditions.
Stability	Availability and accessibility must ensure that supply is stable and permanent.
Acceptability	Cultural or consumer accept ability also implies the need to take into account, as much as possible, values that are not linked to the nutritional content of food, but rather to the food itself or its consumption, and the concerns of the well-informed consumer regarding the nature of the available food supply.
Principles	Description
Human dignity	The requirement to respect and value human life; human rights holders; the assertion of rights.
Non-discrimination	Affirmative action and special attention to the most vulnerable groups; non-discrimination based on cultural, economic, or social origin, ethnicity, gender, language, religion, political affiliation, or other factors.
Empowerment	Accurate information, the ability to identify violations, and the capacity to hold the government accountable.
Participation	Qualified information, data transparency, mechanisms for active participation including legal subjects; evaluation of programs for individual development and poverty reduction.
Accountability	Establishment of transparent goals and processes for development and poverty reduction. States are responsible for these actions and must be accountable.

RESULTS AND DISCUSSION

Filters, protagonists, and scenarios: a portrait of the guidelines

The selected documents address evidence-based guidelines and recommendations regarding pharmacological and non-pharmacological medical treatment for individuals with acute myocardial infarction; dyslipidemias and fat consumption and their influence on the development of cardiovascular diseases and hypertension. Between 2015 and 2021,13 documents were identified on the SBC website, 5 (five) of which were selected based on the exclusion criteria and as described in Table 2.

Table 2. Guidelines, Position Statements, and Standards of the Brazilian Society of Cardiology (SBC) by year of publication and issuance.

Document	Year of Publication	Preparation	Authors'professional category (No.of authors)
V Guidelines of the Brazilian Society of Cardiology on the Treatment of Acute Myocardial Infarction with ST-Segment Elevation	2015	Brazilian Society of Cardiology	Physicias (all authors)
Update of the Brazilian Guideline on Dyslipidemia and Prevention of Atherosclerosis	2017	Department of Atherosclerosis of the Brazilian Society of Cardiology; Brazilian Society of Diabetes (SBD); Brazilian Society of Endocrinology and Metabolism.	Physicias (44) Nutritionis (4) Physical Educator (1) Pharmacist (1) Chemist (1) Notfound (7)
Brazilian Guidelines on Hypertension	2020	Department of Hypertension of the Brazilian Society of Cardiology; Brazilian Society of Hypertension (SBH); Brazilian Society of Nephrology (SBN).	Physicians (73) Nutritionists (3) Physical therapists (2) Physical educators (2) Biomedical scientist (1) Biological Sciences (1) Music Therapist (1) Not found (10)
Position Statement on Fat Consumption and Cardiovascular Health	2021	Department of Atherosclerosis of the Brazilian Society of Cardiology	Physicians (17) Dietitians (16)
Guidelines of the Brazilian Society of Cardiology on Unstable Angina and Non-ST-Segment Elevation Acute Myocardial Infarction	2021	Department of Clinical Cardiology of the Brazilian Society of Cardiology	Physicians (64) Not found (5)

The publication of medical guidelines is based on consultation with experts in a specific field to systematize up-to-date scientific evidence regarding diagnoses and treatments. The documents analyzed were collectively authored by professionals who conduct research and/or have clinical experience in the subject and are affiliated with hospitals, specialized institutes, higher education institutions (university centers, universities, and colleges), graduate programs, as well as private clinics and healthcare companies. The concentration of the mentioned institutions in the south-southeast region is noteworthy, which reveals a regional concentration in the production of this type of knowledge.

A relevant element to the debate, especially from an ethical and reliability standpoint, relates to the presence of conflict-of-interest disclosures. From this perspective, it should be noted that all documents include a specific section dedicated to disclosing the conflicts of interest of each participant in the publication.

It should be emphasized that, although there is no consensus regarding the definition of conflicts of interest, it is understood that any relationship between researchers and industries that has a secondary objective—with potential to influence the primary objective—is considered a conflict ofinterest.[20]

This relationship between physicians, nutritionists, or politicians and companies—whether involving financial interests or not—ultimately poses a risk to scientific discoveries or the development of public policies.[21,22] Although the establishment of certain partnerships between companies and scientific communities is legal, such interaction can exacerbate conflicting and antagonistic relationships between corporate objectives and those of medical-scientific institutions, thereby posing risks to human health.[23] In contrast, civil society and the promotion of social participation, particularly in the realm of political action, can assist public authorities in making decisions that benefit public health.[24] Since all documents include a section on conflicts of interest, they reinforce the importance of transparency in relations between the public and private sectors, preventing actions that are not in the interest of or relevant to public health. Thus, as a form of Empowerment and Participation—principles of the HRAF—the presence of civil society in decision-making spaces is essential.

When examining the professional backgrounds of those who participated in drafting the guidelines, it is evident that the experts are predominantly physicians, with few professionals from other fields included in the team of authors.[25] Consequently, topics more frequently discussed among professionals in other fields, such as the HRAF, may be less frequently mentioned or even overlooked in the selection of guideline content.

It is worth noting that only three publications have at least one dietitian among their authors. “Position Statement on Fat Consumption, and Cardiovascular Health”[26] stands out as the one with the highest number of dietitians, while the “Brazilian Guidelines on Arterial Hypertension”[27] features the greatest variety of health professionals.

The emphasis placed on the presence of dietitians among the authors stems from the fact that activities most closely linked to FNC are commonly attributed to this professional. Consequently, nutritionists are likely the professionals who have the most access to HRAF content during their undergraduate studies and training.[28]

It is worth noting that the documents are organized in a similar manner, with an introductory section presenting definitions and concepts, followed by a discussion of clinical practices supported by evidence. The documents that begin with the section “Introduction” describe the following as their object: to guide healthcare professionals in understanding a specific topic and “[...] convey the best available information to

improve clinical practice [...] prevention and treatment"[27] (p.168), bring benefits to physicians and patients, as well as the "[...] standardization of practices so that clinicians and laboratories can act with confidence, supported by scientific evidence"[29] (n.p).

An analysis of the bibliographic references used reveals the significant influence of international studies on the development of content related to food and nutrition. Furthermore, it is worth noting that some guidelines[27-31] draw upon the collections of international medical organizations and societies, including articles from epidemiological studies and clinical trials.

It is worth noting that scientific studies are often considered important due to the weight of scientific evidence and the level of recommendation they entail and have historically been regarded as essential in helping clinical practice.

In a hegemonic manner, scientific production based on Westernized biomedicine is reproduced across fields of knowledge, prioritizing the quantitative and objectivity[32,33] at the expense of holistic scientific production, which does not proceed from the specific to the general but identifies various influences of patterns and behaviors that converge on the specific.[34] In this sense, the debate on ongoing initiatives that reflect the relevance of decolonizing scientific production deserves special mention, as they advocate for the incorporation of more appropriate knowledge and recognize the need for more complex thinking to address the current health landscape.

The term "coloniality" is related to "a predatory ethical, political, cognitive, and material matrix upon which different institutional forms have been built over time."[35] The production of knowledge, based on conservative and Eurocentric forms of scientific production, masks prejudice against those formerly known as colonized peoples, who, since the period of their "discoveries," have possessed their own forms of expression of customs, beliefs, and knowledge.[32,34] Given this, the existence of challenges regarding the production of scientific evidence used by clinical guidelines is evident, making it a focus for reconsideration and reinterpretation.[33]

Only one document[27] references the *Dietary Guidelines for the Brazilian Population* (GAPB).[36] However, it is possible to identify national references published during the same period as the analyzed documents that provide content relevant to clinical practice, considering other dimensions of nutrition beyond biological aspects, and addressing FNS and HRAF. Notable in this regard is DicaBr,[3] which emphasizes guidelines for maintaining a cardioprotective dietary pattern based on regional Brazilian foods; in addition to reports from the National Council for Food and Nutritional Security (CONSEA): "Prevention and Control of Obesity,"[38] which gave rise to the "Intersectoral Strategy for the Prevention and Control of Obesity"[39] and "Public Policies to Ensure Adequate and Healthy Nutrition."[40]

In addition, several articles published around the same period as the guidelines were found that relate obesity and, indirectly, non-compliance with the HRAF as risk factors for CVDs, since limited access to healthy foods as well as the increased availability and consumption of ultra-processed foods can contribute to the development of cardiometabolic diseases.[13,41-43]

Therefore, the leading role is played by biomedical knowledge and international literature, even though, in the national context, references from the Ministry of Health and other state health agencies have been made available; these, produced in the context of defending the HRAF, incorporate both challenges and possibilities. Considering this overview of the publications, it is evident that some of the filters used may strip

the Brazilian context—marked by diversity and inequities—of many of its colors andnuances, which can hinder the recognition of the need to incorporate the HRAF perspective.

Our Daily "Nutritionism"

In the guidelines, aspects related to food and nutrition are typically addressed under the headings "Non-pharmacological treatment" and/or "Dietary Recommendations." In some of these documents, a strong tendency toward a nutrient-centered approach is evident, one that is detached from issues related to other dimensions of food, as observed below:

> [...] prioritize the consumption of MONO and POLY, along with a limit on saturated fat intake, which aligns with the guidelines of the American Heart Association [...].[27] (p. 170)

> [...] restriction of carbohydrate, sucrose, and saturated or trans-fat intake [...][30] (p. 67)

Interpreting the role of nutrients outside the context of food represents a reductionist view of nutrition, since it is well known that nutrients are not consumed in isolation within a food. Furthermore, there are other determinants of food consumption, such as dietary patterns and distinct social contexts.[36,44] It is worth noting, however, the relationship between unhealthy dietary patterns—based on ultra-processed foods—and the development of NCDs, an association that has been extensively investigated in recent years and was even considered in the development of the new *Dietary Guidelines for the Brazilian Population*.[45]

Prominent in the current context, the concept of nutritionism—or nutritional reductionism—presented by Gyorgy Scrinis,[44] is a key analytical framework for critically reflecting on the challenges and opportunities for dialogue between the CRAN described in the guidelines and the dimensions of the HRAF. Nutritionalism is characterized by a "reductive emphasis on the nutritional composition of foods as a way to identify how healthy they are, and by a reductive interpretation of the role of such nutrients in bodily health"[44](p. 25).

A superficial view of food, based exclusively on nutritional aspects, reinforces the biologistic/medicalizing dimension of food, which tends to highlight only nutritional properties or, as Scrinis[44] puts it, the dichotomy between good versus bad. This reinforces the idea that an isolated food, rich in certain nutrients—commonly called a "functional food"—can be considered "healthy food," while those rich in fats and carbohydrates, regardless of their dietary context, are labeled "unhealthy foods."[46]

Thus, the development of scientific knowledge to guide nutritional care, based solely on nutrients, for the prevention of multifactorial diseases such as CVDs, can contribute to misinformation among the general public and health professionals.[44] In contrast, knowledge that takes into account dietary systems and patterns incorporates dimensions that may contribute to the risk of NCDs and CVDs.[36,47]

It is worth noting that some of the analyzed documents use food group classifications in their recommendations, such as grains, vegetables, fruits, carbohydrates, fats, and proteins.

> A standard diet is recommended that emphasizes the intake of vegetables, fruits, whole grains, legumes, healthy protein sources (dairy products, low-fat poultry [skinless], fish/seafood, and nuts), and non-tropical vegetable oils. One should avoid the consumption of sweets, sugary drinks, and sugar itself, as well as excessive amounts of beef.[31] (p. 236).

The use of this classification is consistent with the first edition of the *Dietary Guidelines for the Brazilian Population*,[48] in which the food pyramid is the centerpiece of nutritional guidance. In this tool, the separation into food groups is based on nutrient composition according to their nutritional functions (complex and simple carbohydrates, protein, and fats) for categorization.[48]

However, with the advent of the NOVA classification,[45] in the second edition of the GAPB and other studies reinforcing its relevance,[45,49,50] it was observed that within the same food group that apparently has the same nutritional or biological function, there are food formulations with combinations of ingredients linked to the development of chronic no communicable diseases (CNCDs), including CVDs.[51,52] Thus, it is not advisable to encourage the consumption of these food formulations.

Furthermore, the guidelines in the second edition of the GAPB explore other dimensions of food more extensively compared to the previous *Guide*, as they encourage cooking, consuming regional foods and products from local producers, as well as communal dining, and cooking as a cultural tradition.[53] These aspects can be reflected in the HRAF regarding the concept of adequacy and the principle of human dignity, as they broaden the vision of the concept of health, which is not tied solely to the biological but to other dimensions linked to human complexity.[54]

Caloric restriction is emphasized by the recommendations, as several references list overweight and obesity as one of the main risk factors for CVDs.[55]

> "The recommended diet for post-AMI prevention is the AHA diet with variable caloric restriction, based on BMI" [...][30] (p. 70).

Despite their decisive role in cardiovascular risk, these conditions are multifactorial and can be managed in various ways, in addition to caloric restriction.[56,57] Several documents demonstrate that obesity is a complex condition related to the implementation of effective public health and social policies.[6,37,47,58]

The excerpt highlighted below addresses lifestyle changes and the promotion of healthy eating from an individual perspective, emphasizing personal responsibility for dietary habits and physical activity.

> Dietary patterns should be restored by encouraging healthy eating, along with guidance on food selection, preparation methods, portion sizes, and possible food substitutions, always in line with lifestyle changes.[29] (p. 18)

It is evident that there is no mention of cultural, social, and economic aspects in the promotion of a healthy "lifestyle," nor is there any discussion of the very use of the term "lifestyle" in the documents, which is characterized as the construction of behaviors on an individual basis, based on an epidemiological risk approach. This reinforces the blame placed on those who adopt these behaviors, ignoring the social determinants of health that contribute to the construction of these behaviors.[59]

National references, such as the GAPB and DicaBr, emphasize the importance of respecting individuals' cultural habits and social context for the promotion of adequate, healthy, and cardioprotective nutrition, in addition to citing the need for government accountability in the implementation of public policies aimed at fostering healthy food systems.[36,37]

Thus, nutritionalism is identified as a significant obstacle to incorporating the HRAF perspective into guidelines, since they focus on nutrient-and disease-centered approaches, making it more difficult to address aspects such as availability, adequacy, accessibility, and acceptability. These are largely related to different dietary contexts, thus taking into account social, cultural, economic, and environmental aspects related to individuals and their living conditions.

Opportunities for Incorporating the HRAF Approach into the Guidelines

Based on an analysis of the Guidelines, it was possible to identify passages that align with the concepts and principles of the HRAF. Given that the realization of the right to food must be achieved progressively through civil society initiatives and state actions,[4] it is worth noting that, to a large extent, official Brazilian publications—especially those produced during the periods when the National Council for Food and Nutritional Security was in effect—incorporate various dimensions of the HRAF.

Both editions of the GAPB recognize that food stems from dietary practices associated with social and cultural meanings.[36,48] The most recent edition adopted the NOVA food classification[45] and placed emphasis on "traditional meals and Brazilian culinary preparations."[53] It presents thefollowing as a golden rule: "Always prefer *fresh* or minimally processed foods and culinary preparations over ultra-processed foods."[36]

An analysis of the Guidelines reveals that, although they maintain guidelines strongly linked to calorie reduction, they now include terms such as "individual and cultural preferences"[27](p. 194), "cultural patterns"[31](p. 236), and "socioeconomic and cultural aspects"[28](p. 530). In this sense, there are opportunities to incorporate debates regarding appropriateness that take into account the diversity of dietary practices among the Brazilian population.

The incorporation of CRAN's individualization is expressed in at least two guidelines. This aspect may represent an opportunity to incorporate cultural, regional, generational, and other diversities that allow for approaches more attentive to appropriateness and acceptability.

The guidelines on hypertension and fat intake[28,27] emphasize the importance of reading labels to understand and identify the ingredients in a given food. They also stress the need to take individual and cultural factors into account during nutritional interventions and highlight the importance of government measures to ensure adequate knowledge about food.

> Reducing salt consumption among the Brazilian population remains a public health priority, but requires a combined effort among the food industry, governments at various levels, and the general public, since 80% of salt consumption comes from processed foods[28] (p. 531)

Thus, a discussion arises regarding the importance of access to information about the foods consumed and the accountability of governments regarding access to and availability of information on foods available for purchase and consumption. Such strategies are related to the principles of empowerment and accountability.[7,19]

In line with the above, reflections on shared responsibility for health care—characterizing the consumer as an active agent in determining their choices based on access to information—make it timely to once again relatethis to the principles of participation and empowerment, as observed in this excerpt:

> Part of the strategy to reduce salt intake is to read the nutritionallabels on all foods and choose those with low levels of salt (sodium chloride) and other forms of sodium, with an

> emphasis on consuming fresh, frozen, or canned vegetables "without added salt" and using herbs, spices, and salt-free seasoning blends for cooking and at the table[28] (p. 563)

Although Brazilian legislation regarding food labeling still requires revisions,[60] it has been introducing new measures, prioritizing easier access to information for consumers and facilitating informed decision-making regarding food choices.[61] Knowledge about food composition and safety regarding nutrient intake are important issues for assisting in more conscious food choices, aiding in health maintenance[60] and for empowering consumers and strengthening the concepts of food sovereignty and FNS, one of the instruments used to guarantee the (HRAF).[62] A critical reading of the Guidelines, in light of concepts and principles related to the HRAF, allows for the identification of gaps and opportunities to incorporate or align with a human rights perspective. Table 3 shows a representation of the presence, absence, and examples of opportunities for including the HRAF in such documents.

Table 3. Guidelines, Position Statements, and Standards of the Brazilian Society of Cardiology (SBC) by year of publication and issuance.

Concepts and Principles	Approach taken/Guidelines that addressed	Examples of opportunities to include and/or expand the approach
Availability	Not addressed	Encourage reflection and identify literature that supports the analysis of the cost of adequate and healthy food.
Appropriateness	Addresses the need to include cultural aspects of food and the individualization of nutritional guidelines. Guidelines: "Position Statementon FatIntake and Cardiovascular Health" "Guidelines of the Brazilian Society of Cardiology on Unstable Angina and Acute Myocardial Infarction without ST-SegmentElevation"	Expand the approach to food culture using culturally referenced diets as a reference in light of the GAPB and other national publications
Accessibility	Not addressed	Propose a discussion and identify literature that supports the analysis of the cost of adequate and healthy food and food availability indifferent regions of the country.
Stability	Not addressed	Propose reflection and identify literature that supports the analysis of the cost of adequate and healthy food and food availability indifferent regions of the country.
Acceptability	Addresses the need to include cultural aspects of food and the individualization of nutritional guidelines. Guidelines: "Position on Fat Consumption and Cardiovascular Health"	Expand the critical approach to include reflections on the concept of Nutritionalism, the NEW Food Classification, and Conflicts of Interest.

Table 3. Guidelines, Position Statements, and Standards of the Brazilian Society of Cardiology (SBC) by year of publication and issuance. Continues.

Concepts and Principles	Approach taken/Guidelines that addressed	Examples of opportunities to include and/or expand the approach
Human dignity	Not addressed	Propose reflection based on epidemiological data regarding the inequities and social determinants of diseases that impact the occurrence of cardiovascular diseases.
Non-discrimination	Not addressed	Encourage reflection based on epidemiological data regarding the inequities and social determinants of diseases that influence the occurrence of cardiovascular diseases.
Empowerment	Addresses the importance of nutrition labeling for the right to choose. Guidelines: "Positionon Fat Consumption and Cardiovascular Health"	To encourage reflection and highlight literature related to Food and Nutrition Education committed to the realization of the Human Right to Food.
Participation	Not addressed	Propose reflections on the importance of monitoring and the participation of health professionals in related public consultations (such as those conducted within the scope of ANVISA).
Accountability	Addresses the relevance of government actions, particularly those concerning nutritional labeling and regulation (such as sodium content in processed foods). Guidelines: "Brazilian Guidelines on Arterial Hypertension"	Identify national legislation relevant to the realization of the right to health and the human right to adequate food.

The incorporation of perspectives that value cultural aspects and the individualization of care provide opportunities for approaches that meet the principles of adequacy and acceptability, which are essential to the treatment of the HRAF. Valuing access to information on food and labeling includes the opportunity to incorporate the Empowerment and Participation approach, pointing toward state accountability.

It is evident that, by including the cultural dimension in the texts of the guidelines and recognizing the right to information through nutritional labeling, opportunities are presented. Furthermore, the human rights-based approach acknowledges that there is a shared responsibility across society but reinforces the importance of recognizing and holding the State accountable for its obligations related to mechanisms of promotion, protection, and provision.

Given the current context of injustices and inequalities, public policies to guarantee the HRAF are essential. In this sense, it is important to recognize the need for the State to address the necessity of implementing measures of significant public health interest regarding the guarantee of adequate nutrition, from a human rights perspective, such as labeling regulations, heavy taxation of ultra-processed products, and the prohibition of selling ultra-processed products in schools, among other measures.[11] Never the less it

must be noted that there cognition of food as a right and the implementation of public policies are constrained and limited by the prevailing capitalist order.[63] In this sense, the stance of academia and scientific organizations regarding the State's commitment to its obligation to guarantee the HRAF is relevant.

Similarly, it is worth noting that Brazilian public policies are based on the concept of adequate and healthy food[64] and that, in the context of a global syndemic,[47,65] it is necessary to consider the need for interconnection between the concepts of healthy diets and sustainable diets, taking into account climate change, food supply, and the global food system.[47,65]

This study has as limitations the lack of analysis of all parts of the selected documents and the limited understanding of the context of the SBC's knowledge-building process (scientific events and other debates held during the drafting process).

FINAL CONSIDERATIONS

The guidelines on angina, acute myocardial infarction, and the treatment of dyslipidemia and atherosclerosis ultimately promote nutritionalism, emphasizing only the nutrient and not the food or dietary pattern. Part of this can be justified by the use of references that conducted intervention studies, using a specific nutrient as a protective or risk factor.

In contrast, guidelines on fat intake and hypertension include national references to FNS and the HRAF, such as the *Dietary Guidelines*, and DicaBr, a dietary program focused on the prevention of CVD.

The principles of Empowerment and Participation are the aspects observed and represent opportunities related to the implementation of the HRAF in nutritional care for CVDs. Challenges would be related to the need to recognize dietary inequities and injustices that may impact Availability, Accessibility, Stability, Dignity, and Non-Discrimination.

Introducing the concept of HRAF and its principles into the development of clinical guidelines is relevant, given the current Brazilian context. The incorporation of these concepts, as well as the public stance of experts and medical societies, can help guide the responsibilities of health care professionals and the State's obligations regarding HRAF.

Expanding the diversity of knowledge, stake holders, and references used in debates and the development of clinical guidelines represents a challenge and significant potential for incorporating different dimensions, including those related to promoting comprehensive care in adequate food and nutrition. This aspect is essential for incorporating HRAF into the various points of the Healthcare Network.

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Contributors

Souza CM participated in the conception of the study, data analysis and interpretation, and writing of the article; Reis EC participated in data analysis and interpretation, critical review, and final approval; Casemiro JP participated in the conception, drafting, and final review.

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