Page 245 to 254

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Food and Nutrition Policies in National Health Systems. The Case of Venezuela

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Abstract

On the basis of concepts such as health system, food and nutritional policies, and following up some indicators, this paper shows the main social, political and economic determinants of Venezuela's nutritional issues, compares with other countries and highlights the importance these problems have in agenda of the chavista and post chavista politi-cal regimes in Venezuela.

Keywords: *Venezuela; Health System; Food and nutritional security*

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Some Conceptual Assumptions

When we refer to Health Policies, we mean a set of programs defined by the different levels of the government and other actors involved, aimed at prevention, suppression and recovery of health problems, identified and prioritized by the different levels of a social organization. This definition leads us to consider the following issues: First, the existence of a political will that understands the governmental task as a public service mechanism for whose provi-sion it is indispensable that both, providers and beneficiaries, participate in the definition of the goals trailed. Sec-ondly, given the fact that these are sets of programs, it is essential that there be a minimum of coherence among them that will make efficiency possible in their administration, effectiveness in achieving their objectives and impact in terms of changes that intended to be achieved. In other words, a government whose priority is the citizen rather than power.

For these reasons, when we refer to National Public Health Systems (NPHS) we point to a structure that results from the historically specific way in which human, technological and financial resources are articulated to fulfill the basic functions of any health system -stewardship, organization, financing and provision of services- according to the pri-orities established by the health policies, with universal coverage and without distinction of any kind among its ben-eficiaries. It should be noted here that unlike the definitions that exist in the current Venezuelan Constitution or in most of the proposals of Law that have been elaborated since 1999, gratuity is not mentioned as an essential feature of the NPHS. And this is so because such gratuity does not exist. It is not a matter of the NPHS being private or having to pay for services, but simply that in a society of citizens and a rational economy, all pay, directly or indirectly for the services they receive or can receive so that payment results in a form of social and intergenerational solidarity.

So the achievements of a given PNHS can be evaluated by the following of the performance in relation with its main functions

Furthermore, the evaluation of a given Health System could be carried out by following up the performance related with its major functions. Hereby, the stewardship would guarantee the coherence of the policies and the process of agreement, especially in an NPHS that works in a decentralized way and even if it is not, the stewardship of the NPHS reflects the political and scientific leadership of the central health organization, to guide and support- as the case may be - groups or regions in the quest to achieve established health goals. In other words, the exercise of this function implies the possession of an important symbolic capital, represented in the political leadership and of an instrumen-tal technical capital that is fundamental in the accompaniment to the different levels of government. Both capitals are the product of a process of accumulation of means and technical capacities that confers legitimacy to the central government (Ministry of Health).

We refer to the organization of the SPNS as the particular way in which service providers (professional colleges, trade unions, scientific societies, etc.), input providers (laboratories, techno-medical industry, others), users (patients, health committees, organized civil society groups,) and financial supporters, are conjoined and re-conjoined periodi-cally in order to fulfill the goals set by health policy and the health authority. This process is supposed to culminate in appropriate responses to people's health demands.

As can be assumed, the interests and points of view of those who constitute the organization of the system are not always coincident and this constitutes the political dynamic within the health sector, the power structure within which the decisions are taken and the policies carried out. It is good to clarify that, despite this complexity in the organization, it is assumed to work for the benefit of the users, or at least, this justifies its existence [1]. However, the actors directly involved do not play equivalent or complimentary roles.

Differences in the management of power come from the historical development of specific institutions. Knowledge about health - in the hands of health personnel initially -especially physicians - conferred for a long time a particular quota of power according to which the other actors had to be subjected uncritically to the opinions of highly qualified professionals, as Parsons affirmed in the Social System many years ago [2].

However, the increase in population education and the widespread dissemination of health information on the inter-net and another mass media, along with a relative loss of prestige among health professionals, has changed the atti-tudes of health system users, making them more critical and analytical about the problems they face or how to main-tain their overall well-being. It should be said that this information is not always accurate and could lead to serious errors. On the other hand, many authors have demonstrated the dependence of therapists on the pressures of the techno-pharmaceutical industry that induces the use of certain drugs to the detriment of others or other forms of therapy, as well as to employ sometimes unnecessary high complexity and high cost technology [3- 5].

The consequence in many countries that favor these trends, are the neglect of healthy lifestyles and inadequate plan-ning of the use of available financial resources for health. In sum, the relations between these actors of the system are changing and getting even more complex in those countries that, like Venezuela, have centralized and authoritarian power structures in health.

The essential function to understand NPHS is financing. The reason for this assertion does not imply economic over-simplification. Funding is understood not only as the volume of financial resources available in health, but mainly as the socio-political process by which priorities are set and financial resources allocated to the different levels of the NPHS. For these reasons, in order to achieve greater efficiency in the use of resources, the role of the stewardship is fundamental. The State must exercise its leadership to achieve conciliation of varied interests and objectives, which is not an easy task, most of all if we think on a decentralized structure. Stewardship must legitimize itself and prove its effectiveness by achieving the planned goals and, at the same time, satisfy the national, regional and local de-mands, and this deserves constant re-negotiation and the renewal of basic agreements among the actors involved.

But the most important thing about financing is that it defines the extent to which a health system is public or private. In other words, what defines the public or private nature of a health system is not the property of the establishments and goods, but who finances the delivery of services. In an NPHS, it is the State that finances and that financing comes from tax and tax sources, although it can also be done through Social Security in a contributory way.

When an NPHS, understood as we have been outlining it, does not finance establishments but services rendered, it does not matter who the first ones belong to, but how many users benefit and the quality of the service, so that the evaluation of the performance has to be centered on how many resources were used to cover the needs met - compar-ing various implementation times - and what were the results in terms of the evolution of the fundamental indicators that express the standard of living and health of populations. From this discussion flows the constant diatribe be-tween privatization and "*publificación*" which is basic when we consider Public Health Systems

National Public Health Services, Food and Nutrition

The previously commented concepts are mainly referred to a NPHS that works in a decentralized and democratic context, with mechanisms of permanent dialogue and update and based on a vigorous and reliable information sys-tem. Obviously that is not the current Venezuelan situation.

At first glance, as one examines the history of the relations between the food and nutritional topics and the health issues in general, it seems that these relations are clear and well defined. We envisage Food and Nutrition Policies (FNP`s) as the set of measures and programs developed by the States with the aim of guaranteeing the right to food through sufficiency, physical and economic accessibility and food quality, to prevent and control states of malnutri-tion due to deficits and excess, ensuring the good health status of individuals and population groups, at all levels of society, emphasizing on the most vulnerable.

Elaborating policies on health and nutrition requires considering the process of demographic transition that occurs globally because it advances along with an epidemiological transition characterized by long-term changes in the pat-terns of death, disease and disability in specific population groups [6].

The history of health and Medicine are full of examples of people whose performance is outstanding. However, for the purposes of what is presented here, a revision of that relationship is required. First, we must leave the central hypothesis on which we center our ideas: The effectiveness of the FNP`s is determined by the social, political and cultural characteristics of the context in which they are formulated. The fundamental consequence of this premise is that a scientific approach must take into account the socio-political dynamics and not only the biological and tech-nical aspects.

What this relationship of determination emphasizes is not the cause of the failure or success of the FNP`s, but those factors that make the necessary causes directly related to health, food and nutritional problems, to act more or less effectively in a context and at a given historical moment. We want to highlight these determinants, without neglecting to consider the direct causal factors of food and nutrition problems.

Our central hypothesis stems from the experience of the real and therefore allows to focus the analysis in the Vene-zuelan case, although brief and limited comparisons with other countries can be undertaken. In fact, for some time now the divergences between political discourse (in the sense of "politics") that pervades our daily life and the con-crete practice of health, that is, the implementation of health policies, are becoming increasingly contradictory. Let us see some examples: In the face of persistent and well-founded complaints about the existing problems of care for cancer patients, widespread deficiencies in the structural failures of public hospitals, and the generalized shortage of inputs and drugs, the national government announced in November 2013 that would prioritize the delivery of dollars to celebrate the approaching Christmas holydays.

We had, then, fresh Canadian pines for those who could pay for, and more deaths by cancer. Recently, in front of the terrible tropical storms that have destroyed some Caribbean islands, tons of humanitarian help have been sent to them, especially to Cuba. Meantime, neighborhoods around the lake of Valencia are about to be damaged by uncon-trolled waters that causes fevers and other illnesses. Social networks are full of innumerable messages requiring antibiotics and other drugs for patients who desperately need them. But there is no answer from the government.

In many countries, especially in the more developed ones, the main objective of sanitary policies related to food and nutrition has been to prevent low weight according to age and height (acute deficit), short stature according to age (chronic deficit) in children and the deficiency of essential micronutrients such as vitamin A, iron and iodine (hidden hunger). However caution was never taken to prevent obesity.

Thus, FNP`s in Venezuela since the 1990`s have focused on ensuring caloric sufficiency, which also allows an ade-quate supply of macronutrients such as proteins, fats and carbohydrates and essential micronutrients such as iron, to prevent and treat anemia, vitamins A, B1, B2 and Niacin, as well as the supply of Iodine, to prevent disorders caused by the deficiency of these micronutrients. In order to achieve these goals the policy have been the massive trade in of caloric foods, reaching numbers that undermine food sovereignty - when imported Calories are more than 30% of the total Calories available in the country - reaching values higher than 40% in 1991 and greater than 45% in 2008. That is, the caloric adequacy achieved since 2005 (110%), has a high degree of external dependence, adding up the fact that since 2005, calories available were estimated by the National Institute of Nutrition (INN) with the consequent inac-curacy, and that the Calories supplied came mainly from fats and carbohydrates [7].

The maintenance of this dietary pattern reduced the percentage of children with severe malnutrition from 2.24% in 1990 to 1.47% in 1997 and 1.24% in 2008, and the weight deficit according to the age of 7, from 6,6% in 1990 to 4.49% in 1994 and 4.18% in 2008. In addition to this, obesity is a problem especially in the adult population, both urban and rural, and in all classes with a prevalence of around 30% in adults since 2006 [8,9], which has increased and reached a 54.95% in 2008-2010 [10], especially in women. Moreover, the prevalence in adolescents and children was 24.08%, which makes the approach of this problem even more complex. On the other hand, the provision of essential micronutrients to prevent deficiencies such as vitamin A deficiency, iron and prevent and treat anemia, has been done through fortification policies for precooked corn flour and wheat, initiated in the years 90, adding water, vitamins B1, B2 and niacin, which is maintained until today [7].

The approach to a problem such as the so-called “double burden” of malnutrition requires a political strategy that laid this topic on the agenda of the government, a subject which, as we have seen, depends, in turn, on the way in which priorities are defined, in addition to the biomedical foundations. Let’s look at the problem of obesity in select-ed countries.

[Table 1] presents some data on obesity in the world. We can observe that, except in the cases of Japan and North Korea, the other countries show quite high percentages of obesity in relation to their total population, being the Unit-ed States of America and México the worse among them. In the case of Mexico, the Ministry of Health has adopted measures to improve the diet of the citizens. However, the contrast with the productive structure is evident [11]. [Table 2] shows trends in food energy supply for Mexico between 1964 and 2000 [12]. While protein availability increases moderately (0.9%) and carbohydrates decrease by slightly more than 10%, fat availability increases by 36.5% over the reference period (1964-1966)

In Venezuela the increase in the availability of Calories has also occurred since 2005, at the expense of fats and a lower proportion of proteins, with a negative variation for carbohydrates. Until 2004, the fats were within the appro-priate limits established by the INN [13] for the Venezuelan population and for the 2005-2007 triennium, reached the upper limit. This pattern of availability of macronutrients could contribute to explain the increase in the prevalence of obesity in the Venezuelan population. In this regard, the government continues with the food subsidy program through the Mercal Mission (Food Market) [14], which is applied in a discriminatory way[1] and offers foods that pro-vide fats, carbohydrates, and to a lesser extent, proteins and with few alternatives for the purchase of fresh vegetables and fruits. [Table 3] shows these characteristics.

Country	Percentage	Diferencie **
Canadá	24,2	2,0
Chile	25,1	2,9
México	30,0	7,8
Reino Unido	26,1	3,9
EE.UU	35,9	13,7
Japón	3,5	-18,7
N Zelanda	27,8	5,6
Hungría	28,5	6,3
Korea	4,1	-18,1
Media OECD:	22,2	

** World Bank (11). OECD: Organization for Economic Cooperation and Development (OECD)*

*** Represents the difference of each country from the OECD average. Source: OECD, 2013*

Table 1: *Percentage of obesity over the total population. Selected countries of the OECD *. 2010*

Periods	Carbohydrates	Proteins	Fat
1964-66	71,3	10,6	18,1
1969-71	71	10,7	18,4
1974-76	69,3	10,6	20,1
1979-81	67,1	11,1	21,7
1984-86	66	10,8	23,2
1989-91	66,9	11,3	22,4
1991-00	64	10,7	24,7
Promedio	67,9	10,8	21,2
Variación (%)	-10,2	0,9	36,5
1964-2000	-7,3	0,1	6,6

Source: CANACINTRA (12). Mexico, 2012.

Table 2: *Trends in food energy supply (%) Mexico, several lapses (Kcal/person/day).*

Periods	Calories(%)[1]	Carbohidrats (%)[2]	Proteins (%)[2]	Fat (%)[2]
1990-1992	99,67	62,67	10,63	26,7
1993-1995	98,7	63,5	10,73	25,77
1996-1998	95,7	62,93	11,5	25,57
1999-2001	97	62,53	11,73	25,67

[1]Lately the implementation of the "Carnet de la Patria" (Homeland ID Card) is discriminating between those who have it, members or the PSUV party and its supporters and those who have not it because of their opposition to the regime.

2002-2004	98	62,39	11,25	26,35
2005-2007	111	61,1	10,67	30,23
Media	99,83	61,82	11,34	27,28
Annual Variation	17,7	-2,23	5,8	11,8
1990-2007	2,3	-0,5	0,2	2,7

[1]Corresponds to the adequacy of the availability of Calories/person/day for the Venezuelan population.

[2]Corresponds to the percentage contribution of the macronutrients in relation to the total calories available.

Source: INN, 2008. Own calculations.

Table 3: *Trend in the availability of energy and macronutrients in Venezuela. 1990-2007.*

In Chile, state policies have been implemented and a set of restrictive measures have been developed for the con-sumption of sugars, breastfeeding stimulants and food advertising watchdogs. Some of these measures are:

- Nutrition labeling of food
- Prolong extended post-natal maternity leave
- Regulation of food advertising for children under 12 years (company self-regulation)
- Prohibition of selling sugared drinks in schools
- Regulation favorable to healthy eating: encouraging consumption of fish, vegetables and fruits
- Promoting physical activity and nutrition education in schools
- Inclusion of cycle paths in infrastructure and housing projects
- Legal regulations on saturated and transgenic fat

However, as can be seen in Table 1, Chile has slightly more than a quarter of its population in a situation of obesity. It is possible that this number, especially because we do not have the historical series of Chile, may have diminished somewhat. What we want to emphasize is that, regardless of the policies and the way in which they are expressed in daily life, the problem persists because its determination is due not only to the implementation of technically well-informed decisions, but to complex political processes in which the economic interests of powerful groups, major social transformations, cultural characteristics, and other important factors beyond the sectoral policies of the Minis-tries of Health, play an important and disregarded role. In contrast, and in support of what we assume here as a gen-eral hypothesis, the cases of Japan and North Korea are opposite examples to the countries referred to hitherto, with 3.5% and 4.1% of obesity respectively (Table 1).

In these cases, it is quite likely that the determinant factors stem from well-established cultural practices in countries with a stable and coherent institutionalism in which “westernization” and progress and development have not signi-fied the death of customs, but the reinforcement of them as resistance, or to increase their ability to subordinate new dietary fashions to traditional ones, by minimizing or destroying their potential harmful health effects. In sum, what we want to sustain is that NAP`s are present in almost all health systems. Differences in the success of its application could be attributed to elements of socio-political, historical-cultural and socio-economic order and not only to bio-logical and technical aspects.

While cultures in North Korea and Japan promote collaborative and collectivized behaviors based on the common good, the individualistic and “libertarian” conceptions of Western societies do not, at any time, guarantee that society as a whole develops healthy behaviors in relation to food and nutrition. It seems to be the traditional and hard-to-solve confrontation between collective well-being, market forces and cultural values.

Food and Nutrition in Venezuelan Health Policies

Already from the very foundation of the MSAS[2] in 1936, Venezuela defined as one of its concerns the nutritional sta-tus of its population and, progressively, new contents related to these issues were incorporated into the Ministry's agenda, especially linked to the medical-pediatric disciplines because of the nature of the programs sponsored by the MSAS. In this Ministry already for 1941 existed the Nutrition Unit that a little later evolved into the category of Divi-sion of the Ministry [15]. By 1945, the National Institute for Popular Food (INPAP) was created. In 1949, the National Institute of Nutrition and the Board of School Canteens will be created [15]. Bengoa [15] synthesizes the currents of nutrition for the moment identifying four definite areas and activities:

- Food analysis, which will later be submitted to the National Institute of Hygiene
- Supplementary feeding that included everything that could today be defined as social programs in food and nutri-tion
- Food Education, incorporated within the preventive activities of the Health Units
- First school of Dietitians and Nutritionists created 1950 to produce the necessary human resources in this field.

All these initiatives show how, from the very beginning, health policy took into account and incorporated into its priorities the issue of food and nutrition, which was also an example for other Latin American countries. But, what happened then? Why did Venezuela come to have the nutritional problems that it presents today? On the basis of our main assumption, let us examine some elements that allow us to support hypotheses in this regard

The production

The data show that in Venezuela, food production is an industry yielded to the fluctuations of an oil-centered econo-my. In fact, Venezuelan urban growth since 1950 reflects a pattern of cultural and economic dependence clearly di-rected from the central economies, especially the United States of America. The Venezuelan entrepreneur became accustomed to solving his liquidness and investment problems through the State subsidies, granted according to the food priorities of the population and, sometimes, taking advantage of the clientele structure of the economy. That happened with milk for a long time and with some crops like cotton. Meat is not an exception. [Table 1] shows the ratio of animal production to population growth between 1961 and 2011. These enormous variations, especially in the mid 80`s, reveal the ineffectiveness of the policies that were formulated and, of course, the change of lifestyles and consumption linked to the oil-based economy.

The same happened when focused on productivity. [Table 4] illustrates what we say and compares it with the effi-ciency and absorption capacity of technological change in the sector [16]. In general, if we compare the Venezuelan Food Production Index (IPAL) with selected countries, we find what is shown in [Table 2]. The small difference be-tween Canada and Chile is surprising. Venezuela is 1.43 points below the world average.

It is appropriate to examine the Venezuelan case shown in detail in [Table 3]. Between 1961 and 1993 could be iden-tified a progressive and sustained growth; since the last year mentioned, the curve shows us uncontrollable varia-tions that, once again, reveal the inconsistency of the respective policies, similar to the trends observed in Figure 1. The production of cereals in kg (Table 4), shows a decrease in production almost at the 1970 levels, reaching only slightly more than 12 kg per 100,000 inhabitants. Taking into account the total population increase in the period considered (1961-2001), which was more than 21 million people, cereal production in Venezuela decreased by 1.9%.

Politics as citizen and state control

Since the Mission Barrio Adentro (MBA) began to operate we understood that health in Venezuela had become a pre-text to push foreign policy leaving the leftovers of a deteriorated primary health care services for those who for his-torical reasons, had limited or no access to medical care. So that the goal of health policy, as well as the goal of most of the social policies developed by Venezuelan

[2]*Ministerio de Sanidad y Asistencia Social*

governments since 1999, has been to act as a mechanism for retaining and increasing political power [17,18]. In the course of these years, we have seen how our hospitals are languishing, the Barrio Adentro modules are closed, foreign exchange is shared between groups affected by the government, while the country is in the hands of uncontrollable delinquency and re-emerging diseases (Malaria, Diphtheria, Measles, among others) returned for their victims of the 21st century.

Countries	1981-1990			1991-2000			2001-2009		
Cameroon	0,54	0,54	0,00	1,73	0,71	1,01	3,36	3,03	0,33
Tanzania	1,57	1,55	0,02	-0,24	-0,44	0,20	6,13	6,13	0,00
Argentina	0,96	0,49	0,47	-0,36	-1,34	1,00	4,04	2,10	1,87
México	-1,49	-5,40	4,14	2,34	1,22	1,11	2,32	1,95	0,36
Brasil	3,17	-1,43	4,66	1,04	0,14	0,90	5,19	5,19	0,00
Dominican Rep.	0,63	-31,00	0,94	1,20	0,43	0,76	4,32	0,00	4,32
Venezuela	-0,54	-5,20	4,91	4,99	3,18	1,75	-0,07	-0,07	0,00
Latin America	0,54	-2,23	2,87	1,78	1,13	0,63	1,87	1,36	0,51

Source: International Food Policy Research Institute (IFPRI), 20

***Table 4:** Average annual growth of total factor productivity (TFP) of efficiency and technical change in low- and middle-income countries.*

This pathetic panorama can be described in another way, with icy figures that show exactly the same thing: Venezue-la is at the edge of an abyss. But such a dilemma appears more clearly and crudely in the case of the growing deterio-ration of health and health services, whose institutionalism is practically inexistent and diluted in a permanent strug-gle for bureaucratic control and political power, be-tween what is and what is not the MBA.

From the year 2013 on, we have been surprised by the incidence of malaria that has reached more than 69,000 cases, more than double the same date of 2012; the violent eruption of Chikungunya and perhaps other forms of hemorrhag-ic fevers. We have been overwhelmed by the frequent complaints of patients, doctors and nurses about the environ-mental conditions and insecurity in which they must exercise their functions; we have been alarmed at the deteriora-tion of most radiotherapy equipment for the treatment of cancer and we have resorted to the need to denounce the violation of the right to health in the country and, specifically, the violation of the rights of the patients of Cancer.

We should also denounce the violation of rights to the healthy eating of all Venezuelans who are forced, through the inflation of the economy and corruption, to pick the supply of MERCAL and other missions under government con-trol with the risk, discussed above, that food offer does not have the right nutritional value, despite the fact that even the consumer has no way to find out about what is he or she acquiring, in terms of nutritional components. Moreo-ver, buying food in these establishments is rendered to the possession of the electronic ration card in partial effect since the beginning of April 2014. Lately, spread distributions of food is submitted to the posses-sion of the so called “carnet de la patria” which act as a key to grasp CLAP[3] bags containing some caloric and canned food coming from different countries and, sometimes, presented as national production.

We have to witness scrutinized garbage on the streets because entire families have nothing to eat or no means to get what they need. In this context, it is difficult to understand FAO’s recognition of Venezuela for its achievements in food and nutritional issues in relation to the millennium goals. But the subject of international cooperation in this field deserves a separate treatment.

[3]CLAP means “Comités Locales de Alimentación y Producción (Locals Comitees of Feeding and Production) which are assumed to represent people`s power for the distribution of food.

The "*Estado clientelar*" that was established from the last third of the 20th century in Venezuela, has again found its way. The slow and difficult corrections that were introduced by the post-perezjimista democracy, culminated with the definitive sanction of the separation of powers in the trial to Carlos Andres Perez. But that could not be perpetuat-ed; the reactionary forces did not allow the modernization of the State and, with the excuse of implementing a new system of a more egalitarian and just life, have paralyzed the productive apparatus, openly violated constitutional provisions, especially essential human rights, and converted Venezuela in a country much more dependent on the central countries of the capitalist system - China and Russia included–than ever before.

Simultaneously, they have efficiently rebuilt the clientele apparatus, discretionary distribution of a growing oil in-come to the detriment of all Venezuelans because it artificially increases incomes in the context of a growing and uncontrollable inflation. This unusual anti-social policy leads to the moral bankruptcy of the population and puts civil society increasingly dependent on a militarized and authoritarian state that tends to perpetuate itself as a dicta-torship.

The relations of determination described here on the causes of nutritional problems do not in any way mean that it is impossible to change reality. Also from health we can build citizenship. The struggle to rebuild health and to give Venezuelans the real opportunity to be healthy, food sovereign and nutritionally sufficient is also the struggle for freedom, human rights and democracy

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