Action on diet
A proposal for the South African Hypertension Society

Effie Schultz January 2004; edited March 2015

I prepared the following proposal at the request of the South African Hypertension Society (SAHS). It was intended to serve as a framework for action on a resolution to lobby the South African government on diet adopted at the society's Annual General Meeting in March 2003. My proposed framework was informed inter alia by documents supplied by the WHO[1,2,3].

Action by the SAHS on the original resolution was misguidedly deferred pending a review by the National Department of Health of legislation on food labelling. When by 2007 the review had not yet been concluded I submitted a slightly modified version of my original motion[4] to another Annual General Meeting. It was there attenuated to include only a reference to reducing salt in bread.

While both motions referred only to the role of salt, sugars, and fats in the prevention and management of hypertension and its associated conditions and complications, the principles that informed any proposed plan of action apply to all aspects of food production, marketing, and consumption as well as to the impact of food in all its forms on health and disease in all age and social groups.

It is/was therefore proposed that the SAHS should:

1. inform the members of the SAHS and the public in general that the SAHS had resolved to lobby the government to:
   - legislate for food to be labelled accurately and in a way that is intelligible to the public in respect of salt (sodium chloride), sugars, and fats
   - oblige the food industry to reduce the amount of added salt, sugars, and fats in commercially processed food including bread
   - inform the public on the dangers of eating too much salt, sugars, and fats.

2. identify South African role-players and stake-holders such as:

   DOH, MRC, MRC-NRC, MRC-CDL,DSA, NSSA, ADSA, SANS, SAHS, LASSA, SEMSDA, PHASA, SAMA, SADA, … (as existed in 2004).

3. set up a new body, work with/in an existing body, or set up a coordinating body from among existing bodies to lobby the government to commit to a plan of action, or to act independently of the government, and/or in partnership with government structures. The plan of action should be to:

1. define the problem – diet related diseases
   by collecting and analysing data as was done in Brazil3 on the:
   - pattern of diet-related morbidity and mortality
   - current, traditional, and local dietary practices and food preferences in institutions (schools, hospitals, old-age homes, …) and in private
   - effect of the food industry, "health" profession, educational institutions, multi-media, civil society, and the state on practices and preferences
   - accessibility of healthy food, relative costs, and food shopping patterns
   - correspondence of current and traditional practices with science-based, industry-independent, and culturally and habitat-relevant guidelines
   - accessibility and scientific reliability of public information on food;

2. agree on an approach – principles and policy:
   - state commitment
   - partnership and cooperation between state sectors (health, education, agriculture, trade and industry, finance, transport, …), industry (food manufacturers, distributors, …), farmers (commercial, small-holder), trade unions, education institutions, media, advertising agencies, civil society structures, WHO and other international organisations, ...
   - evidence-based, feasible, culturally-appropriate intervention modalities within a non-commercial, people-centred, common sense paradigm
   - continuous monitoring and evaluation of the evolving scientific data base, intervention theory and practice, and programme outcomes
   - emphasis on promoting healthy habits (positive approach) rather than on modifying bad practices (negative approach)
   - support of dietary recommendations with legislative incentives: tax rebates, VAT concessions, agricultural subsidies, food stamps, …
   - control of food production, supply, wastage, marketing, food labelling, and advertisements with legislated disincentives: taxation, penalties, …
   - training and deployment of health and medical personnel (old cadres and new [5]) knowledgeable and competent to advise on food and diet;

3. develop intervention strategies – at 4 levels:

   i community level (prevention – first rung in the chain of causality)

   Strategies that could/would inform, encourage, motivate, and empower people to demand and ensure that the relevant powers promulgate and implement legislation on the production, manufacture, distribution, marketing, labelling, and advertising of food and food additives that will:

- encourage and facilitate the consumption of all forms of cereals and pseudo-cereals, legumes, root and other vegetables – and less fruit
- reduce the amount of added salt, free sugars, and fats in bread and other baked products, other processed and packaged foods including infant formula and baby food, and restaurant and "fast" food on sale in formal and informal outlets (spaza shops, road-side stands, markets, …)
- prohibit the use of industrial trans-fats per se and in commercially produced and packaged foods (done in South Africa before latest edit)
- reduce the consumption of meat, including poultry, and full-cream dairy products – and if eaten then sourced from grass-fed animals
- reduce portion size and increase meal frequency (from <3 to ≥5/day)
- support small-scale oil-seed, grain, legume, root, and other vegetable production, processing, and marketing enterprises as well as small free-range poultry and pastured animal farming and fishing
- support vegetable gardens for home consumption and local marketing.

ii institution level

Strategies that could/would encourage and motivate the state to legislate that public and private schools, other places of learning, work-place canteens, hospitals, rehabilitation centres, old age homes, and similar institutions serve and/or otherwise make available for on-site consumption only food that conforms to the above considerations.

iii individual level – general public

Strategies that could/would empower people with knowledge on food by:

- making food a compulsory field of study in all under-graduate schools and institutions for the training of all disciplines in the "health" sector
- facilitating access to healthy food choices – no food deserts
- ensuring that only information on food and diet that conforms to the above considerations is used. This presupposes a measure of state control to prevent the dissemination of wrong information
- labelling food in a user-friendly, accessible, and intelligible format
- using public multi-media pro-actively to promote correct messages.

iv medical treatment level – patient interface

- Strategies that could/would mandate pro-active intervention on food and diet in all health and medical facilities as part of health promotion, disease prevention, and comprehensive disease management.

- Strategies that could/would incorporate advice on food and diet in the management of food-related and other diseases.

When the state is involved in part or fully and even if the state is not involved, the following process could/should follow:

1. prepare and implement a pilot programme in one or a few small sites
2. monitor and evaluate pilot programme/s
3. roll-out adjusted, revised and/or customised programmes to whole country
4. on-going monitoring, evaluation, revision, and customisation of programme/s.

Notes

---

1 Diet, Nutrition and the Prevention of Chronic Diseases. Report of the Joint WHO/FAO Expert Consultation. WHO Technical Report Series, No 916. March 2003.

2 Summary of Finland's experience in changing the cardio-vascular disease risk profile in North Karelia:

- high cardiovascular disease prevalence
- worse in North Karelia
- evidence-based approach
- problem identified by public
- data:
- size (base-line), cause, outcome measures
- death, CVD, risk factor (cholesterol)

1 intervention levels

- medical, community
- cause – all levels (farm, factory, market, preparation, serving)
- food (fat, salt), tobacco

2 partners – public, state, academia, WHO, farmers, food manufacturers, …

3 pilot in North Karelia – then whole country.

3 Summary of Brazil's food programme:

1 food program developed and run by the state

2 mission statement:

- to develop, implement, and evaluate the impact Ministry of Health activities have on improving nutritional conditions for the Brazilian population, in accordance with the National Food and Nutritional Policy as part of the National Health Policy

3 focus on children, pregnant women, obese adults

4 policy:

- guarantee quality for the food products that are consumed in Brazil
- guarantee the promotion of healthy eating habits
- prevent and control nutritional disorders

5 method:

- encourage inter-sectoral actions that provide universal access to food
- guarantee the safety and quality of food products and of services provided in the food products area
- monitor the food and nutrition situation
- promote healthy food and lifestyle practices
- prevent and control nutritional disorders associated with food and nutrition
- promote lines of investigation
- promote development and training of human resources.

4 The 2007 motion read as follows:

Bearing in mind:

- the scientifically confirmed role played by food and diet in the development, maintenance, and progression of all the components of the metabolic syndrome including hypertension with its associated conditions and complications and other diseases as well as in general well-being
- the potentially disastrous economic and personal impact of the rapidly increasing prevalence of these food and diet related conditions and
- the role of the state in influencing the factors that affect what people eat
- it is therefore moved that this meeting resolves to lobby the government of South Africa directly and in co-operation with other local and international scientific and civic organisations to enact legislation that will:

  - set obligatory upper limits on the quantity of added sodium salts, all sugars (including sugar alcohols), hydrogenated and saturated, partially hydrogenated, and trans fatty acids in all food products including bread and fast and restaurant food that is manufactured or otherwise produced for sale to the public in any form or place
  - oblige food manufacturers and other producers of food products including bread, fast foods, and restaurant food on sale to the public to observe these limits
  - require the accurate and intelligible labelling of manufactured and otherwise produced food products including bread, fast foods, and restaurant food on sale to the public, with particular reference to the quantity of sodium salts, all sugars (including sugar alcohols), hydrogenated and saturated, partially hydrogenated, and trans fatty acids present
  - require the placement of warning notices about the potentially cumulative negative effect on consumers' well-being from manufactured and otherwise produced food products including bread, fast foods, and restaurant food that contain added sodium salts, sugars (including sugar alcohols), hydrogenated and saturated, partially hydrogenated, and trans fatty acids.

5 Health educators — for example see:

http://www.effieschultz.com/files/pdf/4-HealthEducators.pdf