

South Africa's salt reduction strategy: Are we on track, and what lies ahead?

Excessive levels of salt consumption contribute to high blood pressure and are a major contributor to cardiovascular diseases and stroke.^[1] Population salt reduction is a cost-effective intervention to reduce chronic disease.^[2] Member states of the World Health Organization (WHO) have agreed to a salt reduction target of 30% towards the WHO's recommended amount of 5 g per day.^[3] In its strategic plan for non-communicable diseases (NCDs) (2013 - 2017), the South African (SA) National Department of Health (NDoH) includes the target to reduce the mean population salt intake to <5 g per day. SA has legislated salt reduction for the main contributors to salt in the diet.^[4] The first set of targets came into effect on 30 June 2016, with the second level of implementation scheduled for June 2019.

It is against this backdrop that 25 key participants from government, non-governmental organisations, universities, research organisations and professional societies met in Cape Town on 2 September 2016 for a meeting hosted by the Heart and Stroke Foundation South Africa (HSFSA). The objective of the meeting was to discuss progress, challenges and the way forward for SA's salt reduction strategy.

It was acknowledged that SA is playing a leading role in salt reduction globally. It was the first country to include mandated maximum salt targets across a wide range of processed foods. Legislation aims to address the 60% of salt in the diet contributed by processed foods.^[5] Effective monitoring mechanisms are needed to assess the impact of the salt legislation on population-level salt intake and health-related outcomes. Beulah Pretorius from the University of Pretoria emphasised that analysis of salt levels in foods presents a number of challenges, which could partly explain noted inconsistencies between industry's self-reported sodium levels and initial independent chemical analysis. These were reported by Melvyn Freeman, NCD chief director at the NDoH, who noted that close consultation with and involvement of the food industry during the development of the legislation has helped to foster a working relationship with laboratory managers and food companies to better understand methodological issues.

Jacqui Webster, director of the WHO Collaborating Centre on Population Salt Reduction at the George Institute for Global Health, Australia, confirmed that the totality of evidence supports the need to reduce salt and that salt reduction programmes are indeed working.^[6] It has been estimated that SA's salt reduction policy will reduce 11% of deaths from heart disease per year and save the government approximately ZAR713 million per year in healthcare costs. At the individual level, healthcare cost savings could prevent 2 000 households being pushed into poverty.^[7]

New data on salt intake in SA presented by Karen Charlton from the University of Wollongong, Australia, and Bianca Swanepoel from North-West University (NWU), SA, provide further support for the government's salt reduction strategy. Preliminary results from the WHO Study on global AGEing and adult health (SAGE) showed that 53% of adults aged ≥50 years ($N=574$) and one-third of 18 - 49-year-olds ($N=312$) had hypertension.^[8] Sixty-five percent of individuals were consuming levels of salt above the WHO target of 5 g per day. Of particular concern was the finding that 40% of younger adults had very high salt intakes, >9 g per day. Similarly, in the NWU study, 65.6% of the sample population ($N=692$) consumed >6 g of salt per day and the majority (92.8%) of the sample did not meet the recommended daily potassium intake.^[9]

High discretionary salt intake (41%)^[5] in South Africans means that a population education and awareness campaign in parallel with legislation is also required. The Salt Watch multisectoral coalition, led by the HSFSA and supported by the NDoH, implemented a 4-month awareness campaign to address people's salt-related behaviours. The campaign included television and radio advertising supplemented by health professional and media engagement, development of educational materials and social media campaigns. Edelweiss Wentzel-Viljoen from NWU said that the outcome of the evaluation was promising, showing a significant positive change in reported knowledge, attitudes and behaviours of the study participants ($N=477$) in respect of excessive salt intake and health (Wentzel-Viljoen *et al.*, 'Evaluation of a mass-media campaign to increase the awareness of the need to reduce discretionary salt use in the South African population', unpublished data, 2016).

Five priority areas were identified as a roadmap for continued action on salt reduction. First of these was the need to support industry compliance with the existing legislation and increase efforts to prepare for the 2019 legislative thresholds, which would include strengthening the monitoring processes and expanding engagement with the food industry to reach out to broader groups, including the informal food production sectors. Second was the importance of better understanding the contribution of foods eaten out of the home (including fast foods) to total salt intake and developing an ongoing strategy to address this factor.

The third priority was implementing the next stage of the Salt Watch campaign to change consumer behaviours. This could be achieved by identifying key behavioural change goals and messages that could then be integrated into broader health communication strategies, for example using the Food-based Dietary Guidelines as a framework to address salt reduction based on a whole-of-diet approach. Ensuring that effective measures are in place to prevent efforts inadvertently exacerbating health inequalities between rich and poor was identified as the fourth priority. Upstream interventions that influence the food environment, including food regulations, are less likely than individual-focused policies (e.g. nutrition education) to result in such disparity. Lastly, efforts need to focus on obtaining additional funds for research and monitoring in order to build capacity to continue to monitor changes in salt intake and salt-related behaviours. This may include integration of salt monitoring into national surveys and identifying opportunities to measure children's salt intake. Given that salt is fortified with iodine in SA, it is also essential to continue to monitor iodine intakes and adjust iodine levels in salt accordingly.

Global action could support ongoing activities, for example engaging multinational companies to encourage salt reduction across products and fast foods on a global scale. SA's salt reduction efforts will potentially have a knock-on effect in neighbouring countries that rely on SA for imports of processed foods. The efforts of SA food companies should also provide the impetus for multinational food companies looking at their own corporate social responsibilities to contribute to reformulate their products to improve the healthfulness of the food supply, particularly in low- and middle-income countries.

The SA legislation to limit salt levels in manufactured foods is an example of what a progressive government can do to improve health at

a population level, with an increasing number of countries following suit.^[10] This multicountry and multiagency consultation reflects not only the importance of this issue in SA, but the importance of our taking the global lead in pressing for change.

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