Policy statement and recommended actions to lower national salt intakes and lower death rates from high blood pressure and strokes in the Eastern Mediterranean Region

Policy goal

A progressive and sustainable reduction in national salt intake in the next 3-4 years by 25% to reduce stroke and heart disease rates within 5 years.

Rationale

Current salt intakes are very high, with an average intake of >12 g per person per day in most countries of the Region. There is no need for extra salt in hot climates and the taste for salt adapts rapidly to progressive but modest rather than rapid drastic reductions in salt intake. Even a small (1 g per person per day) reduction in salt intake will reduce deaths from strokes and heart attacks by more than 7% in each country that takes the appropriate measures to reduce salt intake by 1g per day[1].

Salt is the major cause of high blood pressure, which is itself a major cause of strokes and heart disease resulting in excess deaths and severe disability among survivors. Salt reduction is a very cost-effective public health policy. For example, in the United Kingdom it was estimated that for a total campaign cost of £15 million to reduce daily salt intake, £1.5 billion per year would be saved in health care.[1] Currently in the Region bread, with an average salt content of 1–2%, accounts for 30–40% of all salt intake. Bread is thus the first point of focus, with several industrial groups already taking action, e.g. in Kuwait, Qatar and Bahrain.

Suggested actions

Phase 1: January 2014 Major Initiatives focused on bread production

1) Establish a national taskforce on salt reduction representing key stakeholders and partners[2].
2) Achieve a 10% reduction of salt/sodium in staple bread within 3–4 months. This will reduce salt intakes by about 0.5 g per day in the whole population.
3) Establish salt standards for compliance by all bakers. Several major bakers in the Region are now reducing salt but all bakers need to comply to ensure that bakers with a higher bread salt content do not hinder the population's taste adaptation and thereby gain commercial advantage.

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[1] Prevention of cardiovascular disease. Costing report. Implementing NICE guidance. London: National Institute for Health and Care Excellence; 2010. Available from: http://guidance.nice.org.uk/PH25 accessed 30 October 2012.

[2] Ministry of Health, academia involved in public health, trade, the food industry, retail and catering organizations, nongovernmental organizations.

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4) Promote compliance with standard salt levels by linking government flour/bread subsidies and other incentives to bakers' compliance with the new standards. This approach is strongly supported by the main bakers' associations consulted.

5) Mandate use of iodized salt in local and imported food to ensure adequate maintenance of the population's iodine status and the avoidance of goitre and cretinism.

6) Identify the top five other food contributors to salt/sodium other than bread in the national diet, e.g. cheese, processed meat and others.

7) Review and progressively revise national food standards for bread to reflect the recommended minimum levels of salt/sodium content in bread, i.e. to achieve a 30% reduction in salt/sodium in bread from current levels over an 18 month period.

8) Establish national groups to obtain simple suitable population-based food intake data, a laboratory group for measuring the salt content of specified foods and a national group for monitoring salt intake using 24 h urine measurements.

Phase 2: June 2014

1) Confirm progressive salt changes in national bread production.
   a) Achieve a further 10% reduction, i.e. total 20% reduction, in salt/sodium in all bread sources
   b) Monitor bread industry/bakeries' compliance with salt standards
   c) Monitor use of iodized salt in local and imported foods
   d) Measure salt/sodium content of top five contributors to national dietary salt/sodium intake
   e) Adopt 24 hour urinary sodium excretion testing to measure national sodium intake as recommended by the draft regional protocol (WHO Regional Office for the Eastern Mediterranean, unpublished)[3].

2) Government establishments to start reducing salt content in all food served on their premises by 10% every 6 months over a period of 2 years.
   a) Establish a requirement that all government establishments serving food, e.g. army, police, hospitals, schools, universities, local and national government, record for inspection their salt purchases each month.
   b) Require all these services to reduce their salt use by 10% each 6 months for 2 years.
   c) Establish a monitoring group to ensure a coordinated approach to the changes made by different food industry sectors, compliance with new catering changes in the use of salt and the monitoring of salt intake in the population. This group will benefit from the involvement of civil society groups,food safety/trade inspections and analytical laboratory groups involved in monitoring locally made items in menus.
   d) Establish a catering educational group linked to the national body responsible for educating caterers. This group will start by dealing with salt but also become involved in other policies e.g. ensuring minimum-level trans-fat and much lower saturated fat content in meals.

[3] Governments could consider measuring urinary iodine excretion to monitor progress with iodine deficiency programmes. Moderate salt reduction within the recommended levels for the Region has minimal effect on the population's iodine status.

Phase 3: January 2015

1) Confirm government-based initiatives and compliance with further 10% reduction in salt levels.
2) Engage major national businesses and all caterers to help lower salt intakes.
3) Conduct a public educational campaign focused primarily on caterers and those providing food rather than simply targeting the public in general, supported by a public service announcement and a national advocacy campaign.
4) Engage with general businesses. Major businesses employing substantial numbers of workers have a major opportunity to contribute to the health of their workers by reducing salt in the food provided in their canteens. Chinese steel factory studies[4] show a fall of 75% in deaths from strokes within 5–7 years of changes in salt and fat content of factory canteen meals. Business leaders could ensure that catering staff comply by ensuring that purchase of salt is monitored and declared and made available for scrutiny by staff and concerned civil society organizations.
5) Educate caterers and those responsible for home cooking. Caterers in general are a more specific focus for educational initiatives than the general public as they are crucially involved in the detailed organization of menu planning and cooking. A national programme relating to home cooking can also be considered. There will, however, be a need to overcome common beliefs, such as the need for high salt intake in hot climates.

[4] Chen J, Wu X, Gu D. Hypertension and cardiovascular diseases intervention in the capital steel and iron company and Beijing Fangshan community. Obesity Reviews. 2008;9 Suppl 1:142-5.

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