Social change implies dietary change

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To provide access to adequate and appropriate food is synonymous with good government at local, state, and national levels and internationally (Chopra 2002; WHO 2003) and can be achieved through numerous, complementary routes: policies about what is grown, imported and exported; supports for an adequate and safe food supply; food pricing; food enrichment and fortification, requirements for ingredient and nutrient labeling; income transfer programs; direct food provision; dietary guidance, nutrition education, and nutrition surveillance and research. Parameters for assuring adequate and appropriate food for a given population at any given time are moving targets. Societal changes have effects on food availability and on eating patterns (WHO 2003; Lang & Heasman 2004). Positive societal changes may lead to positive dietary changes, but not necessarily. Advances in technology have clearly improved overall food availability and, therefore, the theoretical possibility of eliminating hunger and undernutrition. However, changes in the global food economy have also led to prevalent overconsumption of fat and sugar and underconsumption of micronutrient rich foods, along with increasing rates of obesity and diabetes. It seems that the obligation of a society is now as much to protect the population from too much food as to provide enough food.

The effects of social and environmental changes on what and how people eat are highlighted in three articles in this issue. Kosonen et al. (2005) report remarkable changes in the use of various types of "special diets" by Finnish adolescents surveyed in 1979 through 2001. They link these trends to changes in the prevalence of diet-related diseases as well as changes in weight concerns and sensitivity to ecological issues. The marginal dietary status of African refugees living in Geneva, Switzerland is reported by Kruseman et al. (2005) based on a qualitative study. Reading this article leaves one with a sense of frustration. Diets of these refugees were characterized by fewer fruits and vegetables and more carbonated sweetened beverages compared to their previous diets. Their ability to recognize and prepare available foods was limited, and weight gain was occurring. The third report comes from a 1998 population survey in Armenia at a time of major social, economic, and political changes following the end of the former Soviet Union (Rossi et al. 2005). The objective was to obtain a baseline for setting public health nutrition intervention priorities for children and reproductive age women in various regions and localities and for both residents and refugees. Anemia and, among the mothers, overweight were identified as problems, but the ability to follow up with corrective interventions was compromised by a drought during the period after this survey was conducted.

These articles remind us of the close link between social and environmental conditions and diet and nutritional status and of the need for continued vigilance regarding the adequacy and appropriateness of food intake in vulnerable population segments, both in countries with stable economies and ample food supplies and in countries in transition to economic stability. These reports underscore that having appropriate foods available, while necessary, is not sufficient to assure nutritional health. Nutrition education and counseling will always be important for helping people identify and take advantage of the best available choices, particularly given that our concept of what is best is also changing on the basis of advances in scientific knowledge and changes in the composition and quality of foods available.

This issue of Social and Preventive Medicine also includes an article that describes a model for how one meets the ongoing need for nutrition education in a way that can be responsive to changes in the social landscape and food

Soz.- Präventivmed. 50 (2005) 131–132
0303-8408/05/030131–2
DOI 10.1007/s00038-005-5022-1

supply. Winkler et al. (2005) describe the development of the "BeKi" (Bewusste Kinderernährung, for conscious child nutrition) initiative for nutrition education of children in Baden-Württemberg, Germany. The need for this program was recognized in 1976, to address nutritional deficiencies, and the program has evolved to address current problems such as childhood obesity, dietary quality with respect to consumption of whole grain products, fat and fiber, and the decreasing frequency of home-cooked meals. Whether having a program like this in place would be associated with a lesser vulnerability to the societal trends that give rise to obesity and chronic diseases cannot be determined. However, this type of program has a high degree of face validity as an important component of an effective strategy.

Social and environmental changes of all types are occurring in all directions – some planned and some unplanned; some abrupt and some more gradual. That these changes influence the context for eating and the resulting dietary patterns of the affected populations is predictable, but policy and programmatic responses to prevent or minimize negative changes seem insufficient such that the new problems are entrenched before we begin to address them. This issue of Social and Preventive Medicine should stimulate reflection on how we can get ahead of the curve.

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